



Date _____

BYRD S. LEAVELL, JR., M.D.

MICHAEL J. OBLINGER, M.D.

DANIEL J. PAMBIANCO, M.D., F.A.C.G.

DAVID H. BALABAN, M.D.

DIEGO A. GOMEZ, M.D.



VIRGINIA P. MICHEL, A.N.P.

LYNN VALENTINE, F.N.P.

AMY E. McDONNELL, F.N.P.

DONNA H. SMITH, F.N.P.

CATHERINE EASTER, F.N.P.

Your physician has referred you to our office for a screening colonoscopy. Because colon cancer is the second leading cause of cancer deaths in the United States and it is 90% curable when found and treated early, your physician feels this is an important procedure to have. I am enclosing with this letter a packet of information regarding this procedure. Please take the time to review and complete this information where needed as it must be filled out completely and accurately in order to schedule your appointment.

We will need the following items in order to schedule your appointment:

- Daytime telephone number(s) and best time to reach you
- Green and white patient information sheet (**fill out in Pen**)
- Pink and white bubble sheet. Please **use a #2 pencil**.
- Medication and allergy sheet with height and weight(**fill out in Pen**)
- Receipt of notice of privacy practices(**fill out in Pen**)
- E-mail address (This is particularly helpful if it is difficult to reach you during normal business hours)
- If your insurance plan requires a referral, you will need to contact your primary care physician to obtain this. It is your responsibility to check your insurance benefit plan to determine if colonoscopy is covered under your policy.
- A copy of the front and back of your insurance card *or* all of the information from both sides written on the green and white page under "Insurance Information."
- Mail back all requested information within 1 week of today's date.

Once your information has been received by the office you will be contacted to schedule a colonoscopy. Screening colonoscopy can be scheduled for up to 2 months in advance. Should you have any questions please contact us at 434-817-8484 extension 6 or by e-mail at screening@cvillegi.com

We look forward to discussing your procedure with you.

Sincerely,

Dwayne Ferguson
Outpatient Colonoscopy Services Specialists

1139 EAST HIGH STREET
SUITE 203
CHARLOTTESVILLE
VIRGINIA, 22902 4855



TEL: 434-817-8484

FAX: 434-817-8490

info@cvillegi.com

www.cvillegi.com



Byrd S. Leavell, Jr., M.D.
Michael J. Oblinger, M.D.
Daniel J. Pambianco, M.D.
David H. Balaban, M.D.
Diego A. Gomez, M.D.

Virginia P. Michel, A.N.P.
Lynn Valentine, F.N.P.
Amy E. McDonnell, F.N.P.
Donna H. Smith, F.N.P.
Catherine Easter, F.N.P.
Thedra Nichols, FNP
Erin Marley, FNP

1139 East High Street
Suite 203
Charlottesville
Virginia 22902-4855

TEL: 434/817-8484
FAX: 434/817-8490
info@cvillegi.com
www.cvillegi.com

Important Information For Anthem and Cigna Beneficiaries Undergoing Screening Colonoscopy

By scheduling a screening colonoscopy with Charlottesville Gastroenterology Associates, you will take an important step in reducing your risk for colorectal cancer.

Virginia law mandates that insurers operating within the state provide coverage for colonoscopy as a screening test for colon cancer (§ 38.2-3418.7:1). Your insurer has notified us that we may use the code for "screening colonoscopy" only for those procedures in which no polyps are found. If a polyp is detected and removed Anthem and Cigna no longer consider this a "screening colonoscopy" and might apply your regular medical benefits, which includes your deductible. Therefore, a colonoscopy with polyp removal could result in higher out-of-pocket costs than expected.

As of October 2008 Anthem Virginia State based policies states they will still cover as a screening if a polyp is found. This does not include out of state policies. This can be determined by looking on the back of your card.

By law, Charlottesville Gastroenterology Associates must follow the regulations set forth by your insurance company and is not able to falsify or change the codes of your procedure.

We feel it is very important for you to precede with your screening colonoscopy. If you have further questions or concerns about your insurance benefits or policy, we encourage you to contact Anthem Insurance at (800) 242-7277 or Cigna Insurance at (800) 468-2204. We will be happy to assist you in any way possible.

Sincerely,

The Physicians at Charlottesville Gastroenterology Associates

BYRD S. LEAVELL, JR., M.D.
 MICHAEL J. OBLINGER, M.D.
 DANIEL J. PAMBIANCO, M.D.
 DAVID H. BALABAN, M.D.
 DIEGO A. GOMEZ, M.D.

1139 EAST HIGH STREET
 SUITE 203
 CHARLOTTESVILLE
 VIRGINIA 22902-4855



TEL: 434-817-8484
 FAX: 434-817-8490
 info@evillegi.com

VIRGINIA P. MICHEL, A.N.P.
 LYNN VALENTINE, F.N.P.
 DONNA SMITH, F.N.P.
 AMY McDONNELL, F.N.P.
 CATHERINE EASTER, F.N.P.

PATIENT E-MAIL ADDRESS	FAMILY DOCTOR
------------------------	---------------

PATIENT INFORMATION

SOCIAL SECURITY NUMBER		FIRST NAME		MIDDLE NAME		LAST NAME	
ADDRESS						<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
CITY			STATE		ZIP		HOME PHONE
WORK PHONE		CELL PHONE		EMPLOYER		RACE	BIRTH DATE
						AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F

INSURANCE INFORMATION

PRIMARY	INSURANCE CARRIER		INSURANCE CARRIER	
	NAME OF POLICY HOLDER		NAME OF POLICY HOLDER	
	INSURANCE ID NUMBER		INSURANCE ID NUMBER	
	ADDRESS OF INSURANCE COMPANY		ADDRESS OF INSURANCE COMPANY	
	PHONE # OF INSURANCE COMPANY		PHONE # OF INSURANCE COMPANY	
	SEX OF POLICY HOLDER <input type="checkbox"/> M <input type="checkbox"/> F	EMPLOYER OF POLICY HOLDER		
PATIENT'S RELATIONSHIP TO POLICY HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER (SPECIFY)		PATIENT'S RELATIONSHIP TO POLICY HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER (SPECIFY)		

REFERRAL SOURCE

NAME		ADDRESS		PHONE NO.	
<input type="checkbox"/> DOCTOR					
NAME					
<input type="checkbox"/> FRIEND <input type="checkbox"/> YELLOW PAGE AD <input type="checkbox"/> PHYSICIAN REFERRAL SERVICE <input type="checkbox"/> OTHER (SPECIFY)					

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME					
ADDRESS					
CITY		STATE	ZIP	WORK PHONE	
				HOME PHONE	
				EXT.	

PLEASE ALLOW RECEPTIONIST TO MAKE A COPY OF YOUR INSURANCE CARD(S)

PATIENT'S RESPONSIBILITY / MEDICAL RELEASE / ASSIGNMENT OF BENEFITS

I hereby acknowledge responsibility for any professional fees incurred and for obtaining any referral needed.
 I authorize the release of medical information necessary to process my insurance claims.
 I request that payment of authorized benefits be made to Charlottesville Gastroenterology Associates for any services furnished me by them.

SIGNATURE		RELATIONSHIP TO PATIENT		DATE	
-----------	--	-------------------------	--	------	--

PAST MEDICAL HISTORY - Please indicate if you have ever had these conditions.

GENERAL

Present Past

- Diabetes Present Past
- High blood pressure Present Past
- Thyroid disease Present Past
- HIV positive Present Past
- Arthritis Present Past
- High cholesterol Present Past
- Anemia Present Past
- Lupus Present Past
- Cancer Present Past
- Type: _____

HEART

Present Past

- Heart attack Present Past
- Year: _____
- Congestive heart failure Present Past
- Bypass surgery/angioplasty Present Past
- Vascular surgery Present Past
- Valve disease Present Past
- Atrial fibrillation Present Past
- Implantable defibrillator Present Past
- Artificial heart valves Present Past

LUNGS

Present Past

- Asthma Present Past
- Blood clot in lung Present Past
- Pneumonia Present Past
- Emphysema/COPD Present Past
- Sleep apnea (diagnosed) Present Past

UROGENITAL

Present Past

- Prostate problems Present Past
- Kidney stones Present Past
- Kidney disease Present Past

GASTROINTESTINAL

Present Past

- Acid reflux (GERD) Present Past
- Stomach ulcers Present Past
- Diverticulosis Present Past
- Irritable bowel syndrome Present Past
- Crohn's disease Present Past
- Ulcerative colitis Present Past
- Colon polyps Present Past
- Hemorrhoids Present Past
- Pancreatitis Present Past
- Gallstones Present Past
- Hepatitis Present Past
- Liver disease Present Past
- Cirrhosis of the liver Present Past

NEUROPSYCHIATRIC

Present Past

- Stroke Present Past
- Seizures Present Past
- Migraines Present Past
- Depression Present Past
- Alzheimer's disease Present Past
- Alcoholism Present Past
- Drug Abuse Present Past

SURGERIES - Please indicate if you have ever had these surgeries and the year.

Year

- Appendix removed Year _____
- Gallbladder removed Year _____
- Uterus removed Year _____
- Ovaries removed Year _____
- Hemorrhoids removed Year _____
- Gastric bypass Year _____
- Hernia repair Year _____

OPERATIONS - Please list any other operations and the year.

Year

ILLNESSES - Please list any other illnesses requiring hospitalization.

Diagnosis Year

Please list any other medical conditions.

Please list any allergies you have.

Patient _____

Date: _____ Time _____ AM / P.M.

1. I hereby authorize Dr. _____ and/or such assistants as may be selected by him to perform upon _____ Myself _____ the following operation(s) and/or medical procedures:
Esophagogastroduodenoscopy, possible dilation/injection/thermal coagulation/biopsy, and conscious sedation
Risks: bleeding, infection, perforation, reaction to medication for conscious sedation
Alternatives: X-ray studies, surgery, do nothing
(To be done on: _____ / _____ / _____)

2. I acknowledge by my signature below that the nature of my condition, need to treat such condition, operations or procedure(s) necessary to treat my condition, possible side effects, complications, and risks associated with the operation(s) or procedure(s), and possible alternatives to the operation(s) or procedure(s) have been explained to my satisfaction by the above named physician or his designee.

3. It has been explained to me and I understand that during the course of the operations or procedure(s), unforeseen conditions may be revealed or urgent situations may arise that necessitate an extension of the original procedure or operation, or additional or different operations or procedures than those set forth in paragraph 1 above. I therefore authorize and request that the above named physician, his assistants, and his designees, perform such extension, additional, or different operation(s) and/or procedure(s) which in his professional judgment are necessary or desirable.

4. I acknowledge that no guarantees have been made to me concerning the results of the operation(s) or procedure(s).

5. I agree that any tissues, organs and body fluids removed during the course of the operation or procedure may be examined, documented, preserved and/or disposed of in whatever manner may be considered proper for the purpose of diagnosis, study and advancement of medical knowledge.

6. I consent to the release by the hospital laboratory of any tissue or reports to any medically related agent acting on my behalf for the purpose of diagnosis, study or treatment.

7. I release the hospital, laboratory, its employees and agents from any claims that may arise in connection with damage to any tissues, organs, or body fluids in delivery or by the receiving party, provided that appropriate care in the selection of a delivery system has been exercised.

8. Allergies (drugs, food, etc): _____

9. Medications currently being used: _____

10. I acknowledge that all blank spaces of this document have been either completed or crossed off prior to my signing.

Video: Viewed Previously Viewed Declined _____
(Signature of patient or person authorized to consent for patient)

Date: _____ Time: _____ AM / P.M.

Witness: _____ Relationship: _____

I certify that all the blanks in this form were filled in prior to signature, and the contents of this form, including filled in blanks, were explained to the patient or his representative before requiring the patient or his representative to sign it.



Signature of physician obtaining consent



DIGESTIVE CARE CENTER AT CGA
1139 EAST HIGH STREET (LOWER LEVEL)



MARTHA JEFFERSON HOSPITAL
CONSENT TO OPERATION OR OTHER LISTED MEDICAL PROCEDURE

This is a sample consent form. You will be asked to sign a similar form on the date of your exam. This sample is for information purposes only.



Charlottesville and Augusta Gastroenterology Associates, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that a copy of the **Charlottesville and Augusta Gastroenterology Associates, P.C.** Notice of Privacy Practice is available upon request.

Patient Signature

Date

Legal Representative if applicable (Print)

Legal Representative (Signature)

Relationship to Patient

Date

In order to protect your privacy, we feel it is important to know with whom we have permission to discuss your healthcare. Please list anyone who our office can release your healthcare information to other than your family physician. You may change this at any time.

FOR OFFICE USE ONLY:

Charlottesville and Augusta Gastroenterology Associates, P.C. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

- The CGA/AGA, P.C. Notice of Privacy Practices is available to this patient at the time of his/her initial appointment, or if this party is an existing patient, at the first office visit on or after April 14, 2003.
- The CGA/AGA, P.C. Privacy Officer or his/her designee will discuss any issues a patient has towards signing this receipt of information document with specific reasoning being completed by the CGA/AGA, P.C. representative below.

CGA/AGA, P.C. Representative Signature

Title

Date