COLON•RECTAL
Surgical Associates

www.colonrectal.net

James J. Zalucki M.D., FASCRS
Vincent Cifello M.D., FASCRS

4801 DORSEY HALL DRIVE, Suite 216
ELLICOTT CITY, MD 21042
T 410.730.1712 F 410.730.1713

404 S. CRAIN HIGHWAY, SUITE 111
GLEN BURNIE, MD 21061
T 410.760.9996 F 410.582.9314

Welcome to Colon Rectal Surgical Associates

To Schedule Your Colonoscopy:

PLEASE RETURN THE FORMS TO US AS SOON AS POSSIBLE ALONG WITH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

MAIL/DELIVER TO:

COLON RECTAL SURGICAL ASSOCIATES
4801 DORSEY HALL DRIVE, SUITE 216
ELLICOTT CITY, MD 21042

COLON RECTAL SURGICAL ASSOCIATES
1404 S. CRAIN HIGHWAY, SUITE 111
GLEN BURNIE, MD 21061

OR

IF YOU WISH, YOU MAY BRING THE PAPERWORK TO OUR OFFICE BETWEEN 9:00 AM - 3:00 PM

TO SCHEDULE THE DATE AND TIME.
CALL 410-730-1712 (Dr Zalucki) or 410-760-9996 (Dr Cifello)

COLON and RECTAL CANCER SCREENING

Colon and Rectal Cancer is the third most common form of cancer, striking 140,000 people annually. It is the second most common cause of cancer death, responsible for 56,000 deaths each year. Fortunately, screening examinations can prevent colorectal cancer or identify it at its earliest and most treatable stages. The cancer begins in benign, non-cancerous polyps. Finding and removing these polyps will prevent colorectal cancer. If a cancer is found before symptoms develop, it is 90% curable. However, once rectal bleeding, a change in bowel habits, persisting abdominal pain, or unexplained weight loss occurs, only 50% of cancers can be cured.

Screening tests include a Barium Enema, Virtual Colonoscopy (CT Scan), Sigmoidoscopy, or a Colonoscopy. The BE and CT Scan are x-ray tests which can visualize the entire colon, but cannot remove a polyp or take a biopsy. Flexible Sigmoidoscopy examines the rectum and only the left half of the colon; Colonoscopy the entire colon and rectum. Traditionally, it was believed that most polyps and cancers were in the lower half of the colon, but recent studies indicate that they are equally distributed between the right and left sides of the colon. Furthermore, 50% of advanced polyps and cancers found on the right side of the colon did not have polyps in the lower colon, which would have been seen by Sigmoidoscopy. These would have been missed, until they grew to an advanced stage and caused symptoms. This is why Colonoscopy rather than Sigmoidoscopy is the preferred Screening examination.

Maryland State Law (15-837) mandates insurance companies to provide Colorectal Screening Coverage in accordance to the latest screening guidelines issued by the American Cancer Society. These guidelines can be reviewed at www.cancer.org They recommend that an asymptomatic individual 50 years or older with no other risk factors should be screened by: 1) Annual stool testing for occult blood and Flexible Sigmoidoscopy every 5 years, or 2) Colonoscopy every 10 years, or 3) an Air Contrast Barium enema every 5 to 10 years.

COLON RECTAL SURGICAL ASSOCIATES, LLC

Name: ______________________ **Age**: ______ **Primary Care**: ____________________

Are you experiencing? (If YES, please explain)

Y N **Rectal Bleeding** ____

Y N **Change in Bowel Habits** (narrowed stools, new-onset constipation or diarrhea)

____

Y N **Persisting Abdominal Pain** ______________________________________

Y N **Unexplained Weight Loss** _______________________________________

Y N **Anemia** ____

Y N Other problems with your bowels ___________________________________

Have you?

Y N **Family Members who have had Colon Cancer?** ____________________

Y N **Personally had Colon Cancer or Polyps?** ___________________________

Y N **Personally had Ulcerative Colitis, Breast Cancer, Uterine Cancer, or Ovarian Cancer** ____

Previous Colon Examinations (Colonoscopy, Sigmoidoscopy, Lower GI/Barium Enema)? When?

____

____

Medical Conditions (High Blood Pressure, Diabetes, Sleep Apnea, Need Antibiotics for Dental procedures or Surgery, etc.)____

____

Prior Surgeries: ____

Allergies (includingLatex):____

Medications (including Aspirin, Coumadin, Plavix, and blood thinners): ______________________

____

____

(((To be filled out by Physician)))

PEx: Temp _____ BP _____ HR _____ RR _____ HT____ WT____ (__ See Nursing Flow Sheet)

Mental status: Oriented to person, place, time: __Y __N Recent & Remote Memory: __ nl. __impaired

CV: Heart sounds: __nl __Murmur Abd aorta __nl __AAA

Lungs: Effort: __nl. __Intercostals retractions, Accessory muscles, Diaphragmatic

Ascultation: __nl. __Wheezes, Rhonchi, Rubs, Rales

Abd: Tender: __N __Y Distended: __N __Y Masses: __N __Y Liver/Spleen: __nl __enlarged

Hernia: __N __Y Bowel sounds: __nl __ hyper__hypo

Colon Cancer Risk: High (G0105 , 45385-GA) **Plan**:__ Proceed with Colonoscopy

Ave (G0121, 45385-GA) __ Other:________________________________

The History & Physical was performed on ___________ by:____________________________(Physician Signature)

□ James Zalucki, MD □ Vincent Cifello, MD

COLON RECTAL SURGICAL ASSOCIATES, LLC

CONSENT FOR COLONOSCOPY

Name of Patient:______________________________ Date:_________________________ AM/PM

1. My doctor has recommended the following procedure: **COLONOSCOPY WITH POSSIBLE POLYP REMOVAL AND/OR BIOPSY.** A Colonoscopy is a way of directly inspecting the inside of the colon and rectum. A long, flexible, lighted tube (colonoscope) is used to diagnose problems of the colon and rectum, perform biopsies, and remove colon polyps.

2. **CONSENT:** I consent to have the procedure described above performed by my doctor as the surgeon-in-charge. The surgeon-in-charge may designate other medical personnel to assist in the procedure. I consent to the photographing of appropriate portions of my colon or anorectum, for medical or educational purposes. I consent to the administration of such analgesics, sedatives, and/or anesthetics as deemed advisable with the exception of any stated allergies. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor, or employee of the facility, I consent to testing for HIV and Hepatitis.

3. **INDICATIONS FOR PROCEDURE:** The reason for this procedure is to evaluate your symptoms, an abnormal test, or to determine whether a polyp, cancer, or inflammation may be present.

4. **METHOD, ALTERNATIVES, AND RISKS:** The doctor has explained the details of the procedure (including conscious sedation), alternatives, outcomes, and associated risks and possible complications to me, to my satisfaction. Alternatives include: No evaluation; X-ray evaluation (Barium Enema); or Empiric treatment with medication. I understand that every conceivable risk and complication could not be explained to me. The main complications specific to this procedure are as follows:

A. **BLEEDING:** (Approximate risk less than 0.5%). This may result in the need for a blood transfusion. This carries the risks of transfusion reaction, hepatitis, or AIDS (Acquired Immune Deficiency Syndrome).

B. **PERFORATION (TEAR/PUNCTURE):** (Approximate risk less that 0.5%). On rare instances the bowel may be injured; requiring hospitalization, bowel rest, IV fluids, and antibiotics. Surgery may be needed to repair the injury. This may involve direct repair of the perforation, removal of a portion of the colon, and/or a temporary ostomy (opening of the bowel onto the skin with stool emptying into a bag).

C. **INFECTION:** A biopsy, polyp removal, or small tear may result in an infection (abdomen/pelvis, colon/rectum, heart valves, or other sites) which could require hospitalization and antibiotics.

D. **ALLERGIC REACTION TO MEDICATIONS** (sedating medicines, antibiotics, etc.)

E. **DEVELOPMENT OF ABNORMAL HEART RHYTHM, HEART ATTACK, LOW OR HIGH BLOOD PRESSURE**

F. **RESPIRATORY FAILURE:** Inability to adequately breathe or asthma.

5. **NO GUARANTEE:** **No** guarantee has been made to me about the outcome of the procedure. I understand that sometimes it is not successful. Occasionally, the rectum and entire colon may not be able to be examined (incomplete colonoscopy) and additional testing, such as a Barium Enema, may be necessary. Additionally, the problem may not be seen (i.e. a polyp, cancer, etc. may be missed) or the polyp not able to be retrieved for evaluation. Undergoing a colonoscopy does not guarantee that you will not develop a colon or rectal cancer in the future.

6. **COMPLICATIONS AND UNFORESEEN CONDITIONS:** I consent to any additional procedure that good medical judgement indicates should be performed to deal with any complication or unforeseen condition, if it seems medically undesirable to delay the procedure until my further written consent has been obtained.

7. **TISSUE:** I consent to the study, use, and disposal by Hospital of any tissue or parts, which may be necessary to remove.

8. **PREGNANCY:** I certify that to the best of my knowledge I am not pregnant. I understand that a colonoscopy, surgery, or X-rays may harm unborn children. I understand that by signing this consent form I am agreeing to inform my doctor immediately if I learn I am pregnant after signing this form.

9. **CERTIFICATION:** By signing this form I certify that I have had my eighteenth (18th) birthday or I am married, pregnant or a parent.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE WITH WHAT IT SAYS.

PATIENT'S SIGNATURE: WITNESSED BY:

______________________________ ______________________________

Patient Name Date Date

I, or my staff, have explained the above information to the patient, and believe that he/she understood our discussion. The patient was offered a copy of this consent form.

____

Vincent Cifello, M.D., FACS, FASCRS
James J. Zalucki, M.D., FACS, FASCRS

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PATIENT REGISTRATION

COLON RECTAL SURGICAL ASSOCIATES, LLC
WELCOME TO OUR PRACTICE! ACCOUNT #________

LAST NAME ________________________FIRST NAME ________________MIDDLE INITIAL_________

HOME ADDRESS____ZIP_______________

PHONE (H) _______________(W) _______________(C) _______________BIRTH DATE_____________

EMAIL: ____

SEX __M __F SOCIAL SECURITY #_________ MARITAL STATUS __S __M __W __D

EMPLOYER ____________________________EMPLOYER'S ADDRESS____________________________

EMERGENCY CONTACT ___________________________________PHONE _________________________

REFERRING PHYSICIAN ___________________________________/PHONE _________________________

PRIMARY CARE PHYSICIAN _______________________________/PHONE ________________________

PRIMARY INSURANCE CO _____________ GROUP # ____________ ID # ________________

INS CO ADDRESS _________________________________PHONE #_____________________

POLICY HOLDER'S NAME ______________________ POLICY HOLDER BIRTH DATE_________

ADDRESS ______________________CITY/STATE _______________ZIP CODE____________

PHONE # ____________ RELATIONSHIP TO PATIENT __SELF __PARENT __SPOUSE __OTHER

POLICY HOLDER'S EMPLOYER __________________EMPLOYER'S PHONE # ____________

SECONDARY INSURANCE CO ____________ GROUP # ____________ ID # _______________

INS CO ADDRESS _________________________________PHONE #_____________________

POLICY HOLDER'S NAME ______________________ POLICY HOLDER BIRTH DATE_________

ADDRESS ______________________CITY/STATE _______________ZIP CODE____________

PHONE # ____________ RELATIONSHIP TO PATIENT __SELF __PARENT __SPOUSE __OTHER

POLICY HOLDER'S EMPLOYER __________________EMPLOYER'S PHONE # ____________

I recognize and agree that I am responsible for payment of all medical services provided for me or my legal dependent by the physicians of Colon Rectal Surgical Associates LLC, regardless of my insurance coverage, and that payment is due within thirty (30) days of the date payment is requested. I agree that in the event that my account must be tuned over for collection, I will be responsible for collection fees, attorney fees, court costs and interest.

I hereby authorize Colon Rectal Surgical Associates, LLC to apply for benefits for any covered services rendered and I request the direct payment of authorized medical benefits (including Medicare, Medigap, Major medical benefits) be made to **Colon Rectal Surgical Associates, LLC** for any services furnished by these physicians. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing Administration and its agents, to my attorney, or to another physician's office.

I permit a copy of this authorization to be used in place of the original copy. This agreement will remain in effect until I revoke in writing, this authorization.

_______________________________ ____________________________

SIGNATURE SEAL DATE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

There are hundreds of different insurance policies and managed care options. Please appreciate the complexity of insurance coverage today. It is impossible to obtain payment for services without having the full cooperation of the patient. We are experts in colon and rectal care, not insurance. We will help you if we can; however, it is ultimately your responsibility to know your insurance policy.

Does your insurance require a referral from your primary care physician? Have you obtained that referral? The referral must be received by the time of your visit or you will be required to pay for the service. Many managed care plans do not issue referral numbers after the date of service. Look at your insurance card. A toll free number is usually listed on the back of the card. Someone with your insurance company should be able to answer your questions.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Returned checks and balances older than thirty (30) days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments canceled without 24 hours advanced notice.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

- I hereby understand that I am responsible for giving "Colon Rectal Surgical Associates, LLC" the correct insurance information.
- I am also responsible for obtaining the proper referral.
- I agree to pay for services for which I failed to obtain a proper referral.
- I agree to pay for non-covered services under my insurance plan.
- I have read, understand and agree to the above information.

Signature: ____SEAL

Date: ____

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PATIENT ACKNOWLEDGEMENT
FOR DISCLOSURE OF BENEFICIAL INTEREST

I hereby acknowledge that Drs. Cifello/Zalucki or their staff have disclosed to me that (1) he holds an ownership interest in Ellicott City Surgery Center and/or Central Maryland Endoscopy; (2) the services (Colonoscopy and/or Surgeries) and/or supplies are available from other facilities in the community; and (3) I have the freedom to choose from where I will obtain these services and/or supplies.

Receipt of this notice must be acknowledged in writing by you and the signed copy will be placed in your medical records.

I, ______________________________ acknowledge that I have received and reviewed this statement of notice.

____ Date________________
Patient/Guardian Signature

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COLON RECTAL SURGICAL ASSOCIATES, LLC
PRIVACY POLICIES
EFFECTIVE 4/14/2003

We are required by law to protect the privacy of your health Information. This notice describes how medical information about you may be used and disclosed and how you can gain access to that information. Please read the document carefully and sign the bottom to acknowledge that you have received it.

The general consent for release of medical records that you sign authorizes Colon Rectal Surgical Associates to disclose the information m your medical record for treatment, payment and health care operations. Your information may be shared with: employees and contractors of thus practice, with other health care providers who are treating you or consulting in your care, with your insurance company or other third party payors responsible for authorizing or paying for all or part of your care, and with our billing service to facilitate billing operations. We may be required by law to disclose records that you have not authorized such as when we receive a subpoena or for public health reasons. This formation may be communicated in the following ways: mail, fax, Internet, phone/voice mail and personal communication.

We may need to contact you by phone to discuss appointments, test results, treatments, referrals, account balances or to return your phone call. We will attempt to contact you at home, but if necessary and if you have provided us with an alternate phone number, we will attempt to contact you at that number. If you are not available, we will leave a message for you to return the call, or to remind you of your appointment or the need for a referral. We will send statements or reminder notices to the home address that you provide us with at the time you registered with the practice, We may disclose your protected health information to your family or other individuals identified by you when they are involved m your care or the payment for your care.

If you would like Information sent to another physician or medical facility, or if you would like us to release information to a life or disability insurer, you must authorize the release of this Information in writing.

You have a right to inspect and/or obtain a copy of your medical record. You may request changes to be made to your medical records. You must make this request in writing with reasons that support your request. We will review your request and if we do not agree with the changes, you are entitled to have your statement added to your medical record. We must maintain a log of disclosures made by us except for disclosures made for treatment. payment and health care operations and you have a right to request a copy of this log.

We trust that you are comfortable with our sincere efforts to maintain the confidentiality of your medical record. If you believe that your rights have been violated, please may contact our Colon Rectal Surgical Associates Physician or you may complain to the Secretary of the US Dept. of Health & Human Services. There will be no retaliation for making a complaint.

We reserve the right to change our privacy practices and to make new policies for protecting the health information of our patients. If we do so, we will issue an updated copy of the privacy policies to all of our patients. You may revoke any consent/authorization provided to us by giving written notice.

I, ______________________________ acknowledge receipt of this privacy policy

______________________________________SEAL ________________________
Signature Date

- I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND OBTAIN A COPY OF THE FULL DETAILED PRIVACY NOTICE.