PLEASE READ AND FULLY COMPLETE ALL OF THE ATTACHED PAPERWORK.

ANY INCOMPLETE FORMS WILL BE RETURNED SO YOU CAN FULLY COMPLETE THEM.

NO APPOINTMENTS MAY BE MADE WITHOUT HAVING YOUR COMPLETED FORMS ON FILE.

COLONOSCOPY PATIENTS PLEASE READ:

It is your responsibility to know your benefits.
Insurance plans have changed over the years. There are too many different plans and it is difficult to quote coverage for our patients. **You** must call your insurance plan before any medical testing to check your coverage details. Your insurance policy may be written with different levels of benefits for preventative versus diagnostic or therapeutic colonoscopy. This means there are instances in which you may think your colonoscopy will be billed as "screening" when it has to be billed as diagnostic or therapeutic.
_____ (initial here) I have contacted my insurance plan and verified my coverage. I am fully aware of my coverage and benefits for any medical services. Our office does pre-certify the procedure, however it is not a guarantee of benefits. The insured must call for benefit questions.

While the guidelines have changed for screening from 50 years old to 45 years old, many insurance plans have not updated their guidelines, you must check with your plan to see of you have coverage. _____ (initial here) that you understand the above and have checked your benefits.

How can you determine which category your colonoscopy falls into? Please let us know which category you fall into:

_____Diagnostic/Therapeutic Colonoscopy: CPT: 45378, 45380, 45385
The patient has past and/or present gastrointestinal symptoms, GI disease, iron deficiency anemia and/or any other abnormal tests.
_____Surveillance or High Risk Colonoscopy: CPT G0105, 45385, 45380
Patient has no symptoms either past or present, is over the age of 50, has a personal or family history of colon polyps, colon cancer, or GI disease. The patient has not undergone a colonoscopy within the last 5 years.
_____Preventative Colonoscopy with a Screening Diagnosis: CPT G0121
The patient is asymptomatic (no gastrointestinal symptoms either past or present), are over the age of 50, have no personal history of colon polyps or colon cancer. The patient has not undergone a colonoscopy ever or not in the last 5 years- or 10 years for Medicare patients.

Your doctor may refer you for a "screening" colonoscopy, but there may be a misunderstanding of the word screening. You must have no symptoms at all for screening. In our medical questionnaire- please write the reason why you are having this exam

After establishing which category you fit into, you should call your insurance company to find out your coverage for this service as well as any out of pocket expense you may be liable for.

I _____ understand the above.
(please sign and date)
The above statement is for Dr. Cooper's professional billing only. I_____, have called my insurance company and verified my coverage. I fully understand my coverage details.

Please be advised- There are several entities involved in your procedure.
Procedures take place at Carnegie Hill Endoscopy -1516 Lexington Avenue
For billing inquiries please call them directly at 212 860 6300
All entities bill your insurance directly, for billing matters please contact the appropriate provider directly.
We can only help with Dr. Cooper's professional charge.

REGISTRATION DATE: _____
(please print)

PATIENT INFORMATION

NAME_____

ADDRESS_____

CITY _____ STATE_____ZIP_____

TELEPHONE (home) _____ (business) _____

Cell_____Email_____

GENDER: M___ F___ Date of Birth:_____
GENDER IDENTITY- how do you see yourself? Male ___Female__
Are you : Hispanic/ Latino Not Hispanic/Latino ___Decline to answer_____
Race: White___ Black/African American____ Am Indian/AlaskanNative___Hawaiian__
Decline_____
Preferred Language_____
Marital Status: Single__ Married__ Divorced__ Separated__Widowed__Life
Partner____ Other_____
PHARMACY PHONE AND NAME # _____
EMPLOYER _____
EMERGENCY CONTACT _____
RELATIONSHIP_____TELEPHONE _____
REFERRING PHYSICIAN NAME AND ADDRESS _____
_____TELEPHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER_____
INSURED NAME_____RELATION_____
ID #_____GROUP#_____PLAN#_____
ADDRESS_____TELEPHONE_____

SECONDARY INSURANCE CARRIER_____
PLEASE INCLUDE COPIES FRONT AND BACK

PLEASE SIGN THE APPROPRIATE FORM

ASSIGNMENT OF INSURANCE BENEFITS (COMMERCIAL)

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents.

I authorize payment of medical benefits directly to Dr. Robert Cooper. I understand that I am financially responsible for all charges incurred.

_____ _____

Signature of Subscriber **Date**

MEDICARE AUTHORIZATION

_____ _____

PATIENT NAME **MEDICARE ID NUMBER**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Robert B. Cooper for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services

_____ _____

PATIENT SIGNATURE **DATE**

Sign the appropriate section:

Medicare Waiver:

_____
PATIENT NAME

Dr. Robert Cooper has advised me that the procedure(s) today, listed below, may not be fully reimbursed by Medicare, as they may not be considered medically necessary by Medicare. Although Medicare may reduce/deny the procedure(s), I have advised the doctor to proceed with the services and I will assume full responsibility for payment.

DESCRIPTION_

Routine colonoscopy

Date: _____Signature: _____

Commercial Insurance (Non- Medicare)

It has been recommended to you to have a colonoscopy for screening purposes with our office. It is our understanding this procedure is for routine reasons only. Through we are willing to perform the procedure, in this circumstance some insurance companies may not agree to reimburse for this service.

I am aware that my insurance plan may not cover this screening exam. I may be fully responsible for all medical bills incurred by this procedure.

SIGNATURE: _____DATE:_____

SERVICE FEE FOR NON-CANCELLATION OF OFFICE VISIT

I, _____ am aware that if I have an appointment scheduled with Dr. Cooper and I am unable to keep this appointment, I will be charged a service fee of $25.00 if I do not cancel within 24 hours by PHONE. Email is not for cancelations.

I understand that by not calling to cancel my appointment, I am holding an appointment in the doctor's schedule that could be used for another patient.

Patient or Responsible Party Signature

SERVICE FEE FOR PROCEDURE CANCELLATION

In preparation for a patient scheduling a procedure with our office, our staff performs several steps to make this happen. We prepare the preparation, contact the pharmacy, call the insurance company for authorization and coordinate the schedule with the surgical center. All of these steps require time and staff. In an effort to reduce the number of cancellations we have been getting, we are now keeping a credit card on file.

You may be subject to a cancelation fee of $250.00 if you do not cancel in a timely manner- I week (7 days)

Patient signature

CREDIT CARD AUTHORIZATION FOR MEDICAL SERVICE/ CANCELLATIONS
DR. ROBERT B. COOPER

CC# _____

SECURITY CODE:_____

ZIP CODE _____

EXPIRATION _____

PRESCRIPTION DATABASE CONSENT FORM

I, _____ give Dr. Robert Cooper's office permission to access Surescripts (prescription database) to view my prescription history. As of August 2013, consulting the prescription database is New York State law for providers, Failure to sign this document will restrict Dr. Cooper from prescribing medications to you.
Patient Signature_____

Name: _____ Date: _____
Height :_____ Weight: _____

MEDICAL HISTORY FORM
ALL INFORMATION IS CONFIDENTIAL

1. Why are you coming in to see Dr. Cooper? (current problem or reason for procedure)

_____
_____

2. Medications & Dose:

_____ _____
_____ _____
_____ _____

3. Allergies to Medication (what kind of reaction?):

_____

4. Habits:

Smoking? Former _____ Current_____
How much? How long? _____
Alcohol? (number of drinks per day)
_____

5. Operations: Date:

_____
_____

6. Hospitalizations: Date:

_____
_____

7. Family Medical History of GI conditions or cancer

_____

9. Personal:

Marital status: _____

Number of Children: _____

Current Occupations: _____

Previous Occupation: _____

10. Other Doctors involved in your care: (name, address, phone number, fax number & specialty)

_____

_____

_____

_____

_____

_____

Thank you.

Health Insurance Portability and Accountability Act (HIPAA)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for Robert B. Cooper, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Robert B. Cooper, MD's Notice of Privacy Practices provides a more complete description of such uses and disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Robert B. Cooper, MD reserves the right to revise its Notices of Private Practices at anytime. A revised Notice of Privacy Practices may be obtained by forward a written or email request to Robert B. Cooper, MD's Privacy Office at 635 Madison Ave, 17th Floor, NY 10022.

With this consent Robert B. Cooper, MD may mail to my home or other alternative location and leave a **message** on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including pathology and laboratory results among others.

With this consent Robert B. Cooper, MD may **mail** to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders, patient statements and material related to my clinical care.

With this consent, Robert B. Cooper, MD may **e-mail an unencrypted email** to my home or other alternative location any items that assist the practice in carrying TPO such as appointment reminder, patient statements and material pertaining to my clinical care procedure results, among others. I have the right to request that Robert B. Cooper, MD restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Robert B. Cooper, MD's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Robert B. Cooper, MD may decline to provide treatment to me.

Signature of patient _____
Print Name:_____
Date:_____
Email address:_____
(limited to administrative)

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):
Name_____ _____ Relationship _____
Name _____ Relationship _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____
Signature of Patient date

NEW YORK STATE SURPRISE BILL LAW

In Compliance with the above New York State Surprise Bill Law, *Effective: March 31, 2015*
Please be advised of the following:
Dr. Cooper does not participate with your medical insurance plan.
You will be registered as a **cash/ private pay patient.** This means that at the time of service you will be paying by cash, check, or credit card. We will submit the claim to your insurance on your behalf so that you can be reimbursed a portion of the bill (if you have out of network benefits).
Dr. Cooper is affiliated with New York Presbyterian- Weill Cornell Hospital (NYP) at 525 East 68th Street, NYC 10065 and Carnegie Hill Endoscopy (CHE) at 1516 Lexington Avenue, NYC 10029.
NYP billing: (212) 746 - 4250
CHE billing: (212) 860 - 6300

York Anesthesia (procedures at Carnegie Hill) - (631) 264-2030
I understand the office of Dr. Cooper is out of network with my insurance plan.
As mandated by the state, I have been advised of the above New York State Surprise Bill.

Procedure Code:	Fee:
Consultation 99244 – 99245	$450.00 – $600.00
Office Visit 99213 – 99215	$350.00 - $450.00
Endoscopy 43239	$1700.00
Colonoscopy 45378 – 45385	$1800.00 - $2200.00
Sigmoidoscopy	$400.00 - $500.00

Patient signature_____

Date_____

THIS FORM ONLY APPLIES IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE PLAN OR YOU DO NOT HAVE MEDICAL INSURANCE. IF YOU DO NOT KNOW IF WE ARE IN YOUR PLAN, CALL OUR OFFICE OR YOUR INSURANCE PLAN DIRECTLY FOR VERIFICATION.