

For our patients: Please note that our virtual colonoscopy procedure involves insertion of a small enema tip into the rectum so the colon can be inflated with carbon dioxide to allow visualization. This commonly causes a brief period of discomfort, cramping or the sensation that an “accident” may occur during the inflation sequences. Our CT technologist will guide you all the way. The images acquired during scanning are then sent to an advanced FDA approved workstation for both 2D and 3D reconstruction so that the radiologist can examine the colon and the entire abdomen in all possible formats.

Please note: If an abnormality is found, it will require a consultation with your doctor and possible removal by a separate procedure. In many cases, smaller polyps can be followed over the years without immediate removal. We advise you visit with your doctor for regular examinations including yearly fecal occult blood testing (stool blood test) and rectal exam.

You may return to normal eating habits and activities upon completion of the examination.

Your results will be mailed to you and your physician.

Finally, most patients find the procedure and the prep easy. However, a small minority of patients find either the prep arduous or the procedure more difficult than anticipated, perhaps due to bowel spasms, etc. Although most people will feel well enough to drive home, it is prudent to have a friend “on call” in case you do not feel up to driving.

APPOINTMENT DATE _____

APPOINTMENT TIME _____

Two Days Before Your Exam

Follow your normal meal routine the entire day. In the morning drink the enclosed 30 ml of Milk of Magnesia.

Reconstitute one of the EZ-Cat barium packets with 2 cups water.

*Drink 1 cup of reconstituted EZ-Cat barium with each of your two largest meals.

The Day Before Your Exam

Reconstitute the second EZ-Cat barium packet with 2 cups water.

*Drink 1 cup of reconstituted EZ-Cat barium in the morning and one in the afternoon.

All Day: Follow a restricted diet consisting of clear liquids: strained fruit juices **without pulp**, (apple, white grape, lemonade, etc.), water, clear broth or bouillon, coffee or tea (without milk or non dairy creamer) You may have the following that **are not** colored red or purple: Gatorade, carbonated or noncarbonated soft drinks, Kool-aid and ice Popsicles). Drink plenty of fluid throughout the day to avoid dehydration. ***Ensure that you have easy access to a restroom. Only take medications prescribed by your doctor, no vitamins or supplements. If you get a headache you may take a liquid or a liquid gel form of relief, no tablets or capsules.***

Follow the instructions on the left hand side of your prep kit.

THE DAY OF YOUR EXAM.....

If you have morning medications, bring them with you to take after your exam.

2 hours before exam

Insert suppository into rectum and retain for as long as possible, then void. This is to help eliminate any residual gas or fecal material.



Front Range Preventive Imaging
Patient Information Form

Today's Date: _____

Last Name: _____ First: _____ MI: _____ Marital Status _____

Sex: M / F Birth Date: ___/___/___ Age: _____ Height: ___' ___" Weight: _____ lbs

SS# _____ (THIS IS ONLY USED TO OBTAIN PREVIOUS EXAMS & LABS AS NEEDED)

Ethnicity: (circle one) Asian Black Caucasian Hispanic Other

To better serve and communicate with you more relevantly we would appreciate your email address. We keep our email list strictly confidential!

Email address: _____

Mailing Address: _____ Apt / Suite: _____

City: _____ State: _____ ZIP: _____ Phone: (_____) _____

Employer _____ Work #:(_____) _____

Emergency Contact _____ PHONE# _____

HAVE YOU HAD A PREVIOUS CT FOR YOUR ABDOMEN AND OR PELVIS YES NO WHERE _____

How did you hear about us: Physician Friend Radio Newspaper

Website Newsletter Other _____



Front Range Preventive Imaging

Virtual Colonoscopy Questionnaire

Reason For Colon Scan: _____

Do you have a **personal history of Cancer**? No Yes

Type: _____ When: _____

Have you had any previous **Abdominal or Colon Surgery**? No Yes

If so what? _____

Have You Ever been Diagnosed with:

Tumors Yes No

What Kind ? _____

Polyps Yes No

What Kind ? _____

Other abnormalities of No Yes

Abdomen or **Pelvis**

Please describe:

Are You having **Abdominal or Pelvic Pain** ? No Yes

Please describe: _____

Do you have any family history of **Bowel Disease**? No Yes

Who? _____

What condition? _____

Do you have any **known colon problems**: No Yes

Please describe: _____

Past **Colon-related medical procedures**? No Yes

Colonoscopy _____when _____Polyp biopsy/removal _____when_____

Barium Enema _____when _____other _____when_____

NAME_____ ***DATE***_____

Do you have a history of **Hemorrhoids**? No Yes

Do you have **Rectal Bleeding**? No Yes

Has there been a recent change in your bowel habits or stools? No Yes

How long?_____

Recent Unintentional Weight Loss: No Yes

Have you seen a physician for the above conditions? No Yes

Physician's Name _____

Medications currently taking: _____

NAME_____ ***DATE***_____



Virtual Colonoscopy Disclosure and Consent

I voluntarily consent and authorize Front Range Preventive Imaging physicians and technologists to administer the testing required to perform a CT Virtual Colonography Scan.

Furthermore, I understand that:

1. The primary purpose of the colon screening is to detect early cancer or other abnormalities when the likelihood of a cure is greater.
2. Although this is an excellent tool, it is not perfect and can miss some abnormalities including cancers at the very early stages of development and should not be considered as a substitute for a complete evaluation by a physician.
3. **If an abnormality is found a recommendation for an optical colonoscopy will be made.** _____ Initial
4. I will be exposed to radiation during the examination.
5. Since CT is very sensitive, it may identify nodules and/or other abnormalities that are insignificant or not cancerous, but may require additional diagnostic tests and/or procedures to evaluate the findings.
6. Such tests and/or procedures may entail additional costs for which I am responsible.
7. Radiology is not a perfect science and it is possible for a radiologist to miss a significant lesion or abnormality by this method.
8. **Front Range Preventive Imaging is not responsible for my follow-up medical care.**
9. **My test results will be made available to the physician of my choice.**
10. If I develop pain, fever, chills or any other unusual symptom or symptoms related to the colon, abdomen or pelvis, I should seek medical attention and advice.
11. The colon will be inflated with CO₂ in order to help visualize the colon.
12. Oral medication may be given to relax the colon.

I have been given an opportunity to ask questions about this procedure and the risks and hazards involved and I believe that I have sufficient information to give informed consent. I certify that I have read this form and I understand its contents.

The report for this procedure contains medical terminology that is likely to require interpretation by a physician.

In order to allow patients to take this test, Front Range Preventive Imaging requires that you:

1. Identify the name of a physician below to whom we can send a copy of your medical report.
2. If you are a female, you must guarantee that you are not pregnant.

I hereby consent that Front Range Preventive Imaging may send a copy of the medical report for this procedure to my physician:

Physician Name

Physician Address

Physician Phone Number

Patient Signature _____ Date: _____



Front Range Preventive Imaging

Policy Regarding Messages

In an effort to protect your privacy, we have developed a policy on leaving medical care messages. We will NOT leave messages with anyone except the patient or legal guardian. We will NOT leave any information on an answering machine / voice mail. UNLESS we have your written permission to do so.

Please read below and consider carefully whom you want to have access to your medical information.

I, _____, give Front Range Preventive Imaging my permission to leave phone messages regarding my medical care and information as listed below. I fully understand that this authorization will remain valid until revoked in writing.

My home / mobile answering machine / voice mail: Phone: (_____)_____

My office / work voice mail: Phone: (_____)_____

My spouse: Name _____ Phone: (_____)_____

Other: Name _____ Phone: (_____)_____

_____/_____/_____
 Patient Signature Date

Financial Policy

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. Any benefits quoted to you are NOT a guarantee of payment from the insurance company.

- Your insurance is a contract between you, your employer, and the insurance company.
- Patients covered under a PPO / HMO plans are responsible for complying with the PPO / HMO rules, regarding written and phone referrals from primary care physicians, if that is a requirement of your plan.
- Failure to comply with the referral requirements of your plan will make it necessary for us to bill you directly for charges incurred during a non-referred visits.
- We will process claims with PPO /HMO plans with which we have a contract agreement, according to that agreement.
- Required co-payments, if applicable, should be made on the day services are provided. You are responsible for all co pays, deductibles, coinsurance, and amounts not covered by your Ins. Co. You will be billed for any balance on your account after the Ins. has paid their portion.

Payment for service is due at the time service is rendered. You are responsible for timely payment of your account, and for any balance remaining after insurance payment has been received. There will be a \$25.00 charge for all checks returned for insufficient funds.

I have read the above information; I understand and agree that I am responsible for payment of services rendered.

_____/_____/_____
 Patient Signature Date



Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Boulder Internal Medicine and Front Range Preventive Imaging, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

Your Health Information Rights

Although your health record is the physical property of Boulder Internal Medicine and Front Range Preventive Imaging, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record (**a reasonable fee will be required**),
- Request an amendment of the health record,
- Obtain a list of the disclosures of the health information,
- Request restrictions on certain uses and disclosures of your information, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Boulder Internal Medicine and Front Range Preventive Imaging is required to:

- Maintain the privacy of the health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to

information we collect and maintain,

- Abide by the terms of this notice, and
- Notify you if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide the updated policy at the time of a future visit or you may obtain a copy of the revised notice by stopping by our facility.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or to disclose your health information after we have received a written revocation of the authorization.

We will provide health information without authorization when necessary to provide you with treatment, to receive payment or prior authorizations from third parties, and for healthcare operations.

Business associates: There are some services provided by or for Boulder Internal Medicine and Front Range Preventive Imaging through contacts with business associates. Examples may include physician services in the emergency department and radiology, certain laboratory tests, and a transcription service. When these services are used, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. We require our business associates to appropriately safeguard your information.

Communication with family: As health professionals, using our best judgment, we may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Contacts: We may contact you to provide appointment or follow-up reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information about you for worker's compensation or similar programs, which provide benefits for work related injuries or illness.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law in specific circumstances, for military or national security purposes, in response to valid judicial or administrative orders, or to avoid a serious health threat.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, or the public.

I have received and read this Notice of Health Information Practices. I fully understand this Notice and have had all my questions answered.

Print Name

Signature

Date

For More Information or to Report a Problem

If you want additional information or if you believe your privacy rights have been violated, you can file a complaint with Boulder Internal Medicine and Front Range Preventive Imaging or contact the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint. The address for the Office for Civil Rights is listed below:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201