

ROCKWALL SURGICAL SPECIALISTS

1005 W. RALPH HALL PKWY, STE. 211, ROCKWALL, TX 75032

PHONE: 972-412-7700

FAX: 972-412-7710

DAVID RITTER, MD

ASHLEY EGAN, MD

JON HARRIS, MD

JOSHUA MARK, MD

COLONOSCOPY SCREENING

Our office has received a request asking us to schedule you for a Screening Colonoscopy.

If you are **NOT** experiencing any problems and only need a Screening Colonoscopy, you do NOT need an office visit prior to the procedure.

Attached you will find the following forms:

1. Patient Information Forms
2. Colonoscopy Bowel Prep Instructions and Prescription
3. Colonoscopy Information Form

When you are ready to schedule, please complete the attached forms and return to our office along with a legible copy of your driver's license and insurance card FRONT and BACK.

****WE MUST HAVE A COPY OF DL AND INSURANCE CARD (LEGIBLE) PRIOR TO SCHEDULING****

PLEASE KEEP THE FOLLOWING FORMS TO REVIEW WITH THE SCHEDULER WHEN SHE CALLS YOU AFTER VERIFYING YOUR INSURANCE BENEFITS:

1. Colonoscopy Bowel Prep Instructions with attached prescription
2. Blank Colonoscopy Information Form
3. **MAIL THE NEW PATIENT INFORMATION FORMS TO THE ADDRESS ABOVE (ATTN: Ann).**

Once we have received ALL requested, completed information, we will verify your insurance benefits and our Colonoscopy Scheduler will be contacting you to schedule your procedure.

If you **ARE** having any problems and need an appointment, please call the office phone number listed above for an office visit.

Thank you!

ROCKWALL SURGICAL SPECIALISTS

PATIENT REGISTRATION FORM

Patient's Name (Last, First, Middle Initial) Date of Birth Social Security Number Driver's License Number

Mailing Address

City State Zip Code

Home Phone ☐ Preferred Cell Phone ☐ Preferred Work Phone ☐ Preferred

Email • May we email you? ☐ Yes or ☐ No

May we leave a detailed message: ☐ Yes or ☐ No Preferred Language Spoken: ☐ English ☐ Spanish ☐ Other _____

Marital Status:

- ☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Legally Separated

Sex:

- ☐ Male
☐ Female

Race:

- ☐ White/ Caucasian
☐ Black or African American
☐ Asian
☐ American Indian
☐ Other

Ethnicity:

- ☐ Hispanic/ Latino
☐ Not Hispanic
☐ Other: _____

PCP/ Family Physician: _____ Referring Provider/ Hospital: _____

How did you hear about our office? _____

Employer's Name Employer's Phone Number Is this Worker's Comp? ☐ YES or ☐ NO

Occupation/ Job Title? _____ How long? _____

Primary Insurance Company ID Number Group Number

Policy Holder's Full Name Policy Holder D.O.B. Relationship to Patient

Secondary Insurance Company ID Number Group Number

Policy Holder's Full Name Policy Holder D.O.B. Relationship to Patient

Patient Signature: _____ ***Date:*** _____

PATIENT MEDICAL HISTORY/INFORMATION

Patient Name: _____ **DOB:** _____

Chief Complaint: _____ **Onset:** _____

Do you have a personal history of:

___ High Blood Pressure	___ Heart Disease	___ Hepatitis	___ Blood Clots/ DVT
___ Cancer	___ Breast Disease	___ HIV/AIDS	___ Pulmonary Embolism
___ Diabetes	___ High Cholesterol	___ Blood Transfusion	___ Sleep apnea
___ Thyroid Disease	___ Malignant Hyperthermia	___ Oxygen Use	___ Dialysis Treatment
___ Other: Please specify _____			

Family History (Please list): _____

Please List ALL of your previous surgeries: ☐ See Attached List ☐ No Surgical History

<u>SURGERY</u>	<u>YEAR</u>	<u>SURGERY</u>	<u>YEAR</u>
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Last colonoscopy? _____ **Last EGD?** _____ **Height:** _____ **Weight:** _____ **BMI:** _____

Please list ALL current medications, dose, amt/day: ☐ See Attached List ☐ No Current Medications

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

Do you take any blood thinners? (Coumadin, Warfarin, Plavix, Xarelto, Aspirin, etc.) _____

Please list your drug allergies: _____ ☐ NONE

Pharmacy Preference: _____

Location/Town: _____ **Phone number:** _____

Do you:

___ Smoke/ Tobacco? How long? _____	___ Have you ever used Tobacco? How long? _____
___ Drink Alcohol? How much/often? _____	___ Diet pills? What kind? _____
___ Do drugs? What/ How long? _____	___ Have you ever used drugs? _____

Have you recently had any of the following symptoms? (check all the apply)

___ Nausea/Vomiting	___ Weight loss	___ Weight gain	___ Chest pain
___ Fever/Chills	___ Seizure	___ Change in appetite	___ Heart palpitations
___ Weakness	___ Double vision	___ Abdominal pain	___ Heart murmur
___ Bleeding problems	___ Vision changes	___ Blood in stool	___ Leg swelling
___ Swollen glands	___ Earache	___ Constipation	___ Edema
___ Difficulty swallowing	___ Headache	___ Hemorrhoids	___ Nipple discharge
___ Acid reflux/heart burn	___ Nose Bleeds	___ Abdominal mass	___ Breast lump
___ Depression	___ Hearing loss	___ Blood in urine	___ Rash
___ Painful joints	___ Itching	___ Painful urination	___ Change in mole
___ Neck pain	___ Diarrhea	___ Shortness of breath	___ Immune problems
___ Jaundice	___ Pneumonia	___ Asthma	___ Allergy to iodine

Patient Signature: _____

Date: _____

PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES AT FUTURE VISITS.

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PH: (972) 412-7700 FX: (972) 412-7710

HIPAA PATIENT ACKNOWLEDGMENT FORM

In signing this HIPAA Patient Acknowledgment form, I acknowledge and authorize, that I hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state laws has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Rockwall Surgical Specialists must have my consent, therefore, I authorize Rockwall Surgical Specialists to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (Check all that apply):

☐ All PHI Information ☐ Test results ☐ Appointments ☐ Other ☐ Surgery Information ☐ Billing/Account information

Please list the name(s) of the person(s) authorized to obtain the above-mentioned information.

(e.g. Physician other than your referring doctor, family members and other specified person(s))

Name:	Relationship:	Phone:	Emergency Contact?
_____	_____	_____	<input type="checkbox"/>
Name:_____	Relationship:_____	Phone:_____	<input type="checkbox"/>
Name:_____	Relationship:_____	Phone:_____	<input type="checkbox"/>
Name:_____	Relationship:_____	Phone:_____	<input type="checkbox"/>
Name:_____	Relationship:_____	Phone:_____	<input type="checkbox"/>

I hereby authorize Rockwall Surgical Specialists to contact me with information, results, or questions, and I acknowledge if I choose to have my information emailed there is a risk of breach.

Printed Patient Name: _____

Patient Signature: _____ **Date:** _____

Patient representative: (Print name and sign) _____

Relationship to patient: _____ Power of Attorney? ☐ Yes or ☐ No Date: _____

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ASSIGNMENT OF BENEFITS

I consent for Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, Dr. Joshua Mark, and staff to render consultation and treatment. I understand that if I am a minor, a parent or legal guardian must be present at the time of consultation. I, the undersigned, certify that I or my dependent, have insurance coverage and that I have provided that information. I also understand that it is MY RESPONSIBILITY to keep the information updated. I understand there is the possibility that Out-of-Network Provider(s) may provide all or part of the Covered Services. You may contact your insurance company for more information. I assign directly to the above-mentioned physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for all procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collections and/or suit, the practice shall be entitled to reasonable attorney fees and cost of collections. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

In the course of your treatment from Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, or Dr. Joshua Mark, you may be referred to, or certain procedures may be performed at a facility that the physician may have a financial interest in. By signing this disclosure, you acknowledge the physician's possible financial interest in this facility and your election to use such facility. You are not required to use any of these facilities and have the option to use an alternative health care facility. Please let us know if you have any concerns regarding the relationship between the physician and facilities.

We would like to inform you that if you are required to have a surgical procedure or medical treatment by Dr. David Ritter, Dr. Ashley Egan, Dr. Jon Harris, or Dr. Joshua Mark the fees that are quoted to you from this office are for the services rendered by our office only. You will need to discuss laboratory, pathology, anesthesiology, and facility charges with those individuals. They each have a separate billing office and have NO AFFILIATION with our office. The amount you are requested to pay at the time of scheduling is an estimated amount, due to your insurance benefits. After the surgical procedure or medical services are preformed, your insurance company will be billed. If there is any remaining balance that you are required to pay, you will receive a statement from our office with that amount on it. By signing this form, you acknowledge that you are responsible for any balances on your account and or any services not covered by your insurance company. I have read the above statement and agree that if my insurance company fails to pay, I accept responsibility for charges incurred.

I have read and understand the above disclosure.

PRINTED PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

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FMLA/Short Term Disability Release of Information Authorization

I, _____, here by authorize Rockwall Surgical Specialists (physicians and staff) to release any information requested from my employer, human resource department, insurance company, or disability company that is in regard to my time off work request, family leave forms (FMLA), disability payments, or time off compensation.

I also understand that at any time I can revoke this authorization by submitting a request in writing. If I need to re-instate this authorization, I must sign a new form with a current date and this request must be presented in person (by the patient) for authenticity.

PRINTED PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

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ROUTINE COLONOSCOPY SCREENING

The majority of insurance companies cover one Routine Colonoscopy Screening every 10 years after the age of 50 under your preventative benefits at 100%.

Rules differ depending on each insurance company and/or group insurance plan. However, it is important to note that, if while performing your Routine Colonoscopy, the physician finds and removes colon polyps, your insurance company has the right to apply this procedure to your surgical benefit versus routine benefit.

We do not change the procedure code or bill the insurance company any differently, however, by law, we have to report that polyps were removed. This may affect how your claim is paid by insurance. Again, all insurance companies and plans have different protocols and this may or may not apply to your particular plan. However, we do want to inform you of possible issues prior to your procedure.

As a courtesy to our patients, we will check your benefits and then forward the information to you as we have received it from the customer service representative at your insurance company.

I have read and understand the above information.

PRINTED PATIENT NAME: _____

RESPONSIBLE PARTY SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

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DAVID RITTER, MD

ASHLEY EGAN, MD

JON HARRIS, MD

JOSHUA MARK, MD

BAYLOR SCOTT & WHITE SURGICARE ROCKWALL

825 W YELLOWJACKET
ROCKWALL, TX 75087
972-772-6166

TEXAS HEALTH SURGERY CENTER OF ROCKWALL

3144 HORIZON RD, STE. 120
ROCKWALL, TX 75032
972-845-1469

TEXAS HEALTH PRESBY HOSPITAL ROCKWALL

3150 HORIZON RD
ROCKWALL, TX 75032
469-698-1000

Colonoscopy INFORMATION

PRE OP: via phone

A NURSE will contact you from the facility no later than the day prior to surgery/procedure to review your personal health history, allergies, and medications.

SURGERY DATE: _____

APPROX. CHECK IN: _____ **APPROX. PROCEDURE TIME:** _____

Due to unexpected emergencies, your arrival/procedure time may change. We will make every attempt to contact you; however, it is recommended that you confirm your times with the facility the day prior to your surgery/procedure.

- **5-7 DAYS PRIOR TO SURGERY:** NO ANTI-INFLAMMATORIES OR BLOOD THINNERS (Aspirin, Plavix, Coumadin, etc.) Tylenol is okay to take for general pain. See the attached list and check with your prescribing provider.
- **You WILL NOT be allowed to drive home following your surgery.** Please make arrangements for a ride home. Taxis or any other form of public transportation will not be sufficient unless it is a licensed medical transport.
- **NOTHING TO EAT OR DRINK AFTER MIDNIGHT THE NIGHT PRIOR TO SURGERY.** If you take blood pressure medications, it is OK with a small sip of water ONLY. Not adhering to this may cause complications with your procedure.
- **CLEAR LIQUID DIET THE DAY PRIOR AND TAKE THE PREP KIT DOSES AT 5:00PM AND 10:00PM.**

Based on the info we received from your insurance or if you are self-pay, we may collect a down payment prior to surgery. We will bill you if there is any remaining balance after your insurance has processed the claim. An insurance specialist from the facility will check your benefits and contact you regarding out-of-pocket expenses for their facility prior to your surgery/procedure. THE FACILITY, ANESTHESIOLOGY, PATHOLOGY AND ALL OTHER PARTIES INVOLVED WILL BILL SEPERATELY AND ARE NOT AFFILIATED WITH ROCKWALL SURGICAL SPECIALISTS. PLEASE CONTACT THEIR COMPANIES REGARDING THEIR SERVICES AND STATEMENTS.

STOP!!!!!!

All blood thinners **5 (five) days** prior to your surgery.

Blood thinners may include:

Aggrenox	Excedrin
Advil	Fish Oil / Omega3 / CoQ10
Aleve	Fragmin
Alka Seltzer	Ibuprofen
Arixtra	Naproxen
Aspirin	Mobic / Meloxicam
Brilinta	Motrin
Celebrex	Plavix
Cilostazol	Pradaxa
Clopidogrel	Prasugrel
Coumadin	Turmeric / Curcumin
Dipyridamole	Vitamin E
Effient	Xarelto
Eliquis	Warfarin

*****Tylenol/Acetaminophen is OK to use if needed*****

DO NOT TAKE FOR 7 DAYS PRIOR TO SURGERY

Ozempic, Wegovy, Mounjaro, Trulicity, Rybelsus, Bydureon, Adlyxin, Byetta, Victoza, Saxenda, Tanzeum, or any weight loss injection

DO NOT TAKE 24 HOURS PRIOR TO SURGERY

Metformin, Farxagia, Actos, Janumet, Glyburide

DO NOT TAKE THE DAY OF SURGERY

Novolin, Humalin, Novolog, Humalog

SUTAB BOWEL PREP

INSTRUCTIONS FOR THE DAY PRIOR TO YOUR COLONOSCOPY

Stay on a CLEAR LIQUID DIET ALL DAY

Clear liquids include:

Water, chicken broth, Gatorade, coffee (no creamer), tea, lemonade, limeade, apple juice, WHITE grape juice, clear soft drinks, Jell-O, popsicles.

DO NOT HAVE MILK PRODUCTS OR ANYTHING COLORED RED OR PURPLE.

THE EVENING PRIOR @ 5:00PM

Complete steps 1 through 4 using one bottle in your SUTAB kit.

1. Open 1 bottle of 12 tablets.
2. Fill the provided container with 16 ounces of water (up to the fill line). Swallow each tablet with a sip of water and drink the entire amount of water over 15-20 minutes.
3. Approximately 1 hour after the last tablet is ingested, fill the provided container again with 16 ounces of water (up to the fill line), and drink the entire amount over 30 minutes.
4. Approximately 30 minutes after finishing the second container of water, fill the provided container with 16 ounces of water (up to the fill line), and drink the entire amount over 30 minutes.

REPEAT ABOVE STEPS @ 10:00PM

Repeat steps 1 through 4 using the other bottle of SUTAB.

- Be sure to finish **ALL** of the SUTAB TABLETS and water.
- Both bottles are required for a complete prep.

GO TO WWW.SUTAB.COM TO PRINT OUT A COUPON FOR YOUR PRESCRIPTION. YOU MAY ALSO PROVIDE THE COUPON TO YOUR PHARMACIST VIA YOUR CELL PHONE IF YOU ARE UNABLE TO PRINT.

SUPREP BOWEL PREP

INSTRUCTIONS FOR THE DAY PRIOR TO YOUR COLONOSCOPY

Stay on a CLEAR LIQUID DIET ALL DAY

Clear liquids include:

Water, chicken broth, Gatorade, coffee (no creamer), tea, lemonade, limeade, apple juice, WHITE grape juice, clear soft drinks, Jell-O, popsicles.

DO NOT HAVE MILK PRODUCTS OR ANYTHING COLORED RED OR PURPLE.

THE EVENING PRIOR @ 5:00PM

Complete steps 1 through 4 using one bottle in your SUPREP kit.

1. Pour One (1) 6-ounce bottle of SUPREP liquid into the cup provided.
2. Add cool drinking water to the 16-ounce line on the cup and mix well.
3. Drink ALL the liquid in the cup.
4. You MUST drink two (2) more 16-ounce cups of water over the next hour.

REPEAT ABOVE STEPS @ 10:00PM

Repeat steps 1 through 4 using the other 6-ounce bottle of SUPREP.

- Be sure to finish ALL of the solution and water.
- Both 6-ounce bottles are required for a complete prep.

OFFICE LOCATIONS

PLEASE NOTE WE HAVE OFFICES IN 5 DIFFERENT LOCATIONS FOR YOUR CONVENIENCE. IF YOU HAVE QUESTIONS REGARDING WHERE YOUR OFFICE APPOINTMENT IS LOCATED, PLEASE DO NOT HESITATE TO CALL AND CONFIRM.

Main Office Phone: (972) 412-7700

Rockwall – In Rockwall Medical Center Building at the corner of Ralph Hall & Summer Lee

1005 W Ralph Hall Pkwy
Suite 211
Rockwall, Texas 75032

Rowlett – Behind Lake Pointe Hospital in the 2-story red brick medical building

6705 Heritage Parkway
Suite 104
Rockwall, TX 75087

Forney – In the same suite as Airrosti Pain Management, next to HEENA Salon

375 Marketplace Blvd
Suite 190
Forney, Texas 75126

Greenville – In the Baylor Scott & White Health Center Building

4400 IH-30 West
Suite 300
Greenville, Texas 75402

Terrell – In the Baylor Scott & White Health Center Building

200 N Virginia Street
Terrell, Texas 75160