



Patient Information Sheet - SCREENING COLONOSCOPY

**\*\*PLEASE READ THE INSTRUCTIONS BEFORE CALLING OUR OFFICE\*\***

Our office has scheduled you for a SCREENING COLONOSCOPY. Patients who have a screening examination have no signs or symptoms, and have a set benefit from their insurance carrier. Patients who are scheduled for screening colonoscopies need to be informed and understand that if Dr. Markowitz identifies a polyp or abnormality, your benefits and coverage for this procedure may change and your insurance carrier will reimburse differently, due to the fact that the procedure becomes a Diagnostic/Surgical colonoscopy at this point. Please use this worksheet to phone your insurance carrier to inquire about your eligibility and benefits for this procedure, as well as how much, if any financial responsibility you may incur. *In network plans sometimes require you, the patient to “share in the cost” of the procedure and these terms are designated by your insurance company and not our office. It is important for you to understand your benefits and that is the purpose of this form.*

Name of Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Rep \_\_\_\_\_ Date of Procedure \_\_\_\_\_

Co-Insurance/Deductible for Screening Colonoscopy \$ \_\_\_\_\_

Deductible Met:  Y  N Remainder of Deductible to be met \$ \_\_\_\_\_

Co-Insurance/Deductible for Diagnostic/Surgical Colonoscopy \$ \_\_\_\_\_

Deductible Met:  Y  N Remainder of Deductible to be met \$ \_\_\_\_\_

\*Any co-insurance and deductibles listed above must be paid on the date of your procedure, or your procedure may be canceled unless other financial arrangements are made in advance.\*

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient’s Signature/Date

\_\_\_\_\_  
Patient MRN \_\_\_\_\_ Witness/Date \_\_\_\_\_  
(For office use only)