CEC
CONCORD ENDOSCOPY CENTER
One Corporate Center at Horseshoe Pond
Suite 201 • 60 Commercial Street, Concord, NH 03301
Phone: (603) 415-9450 • Fax: (603) 415-9455

# AUTHORIZATION FOR TREATMENT: COLONOSCOPY WITH POSSIBLE BIOPSY OR POLYPECTOMY

**DR. MICHAEL J. GILBERT** **DR. ROBERT D. THOMSON** **DR. ROBERT J. CHEHADE**
**DR. BURR J. LOEW** **DR. SAMUEL C. SOMERS** **DR. LEYLA J. GHAZI**
**DR. SCOTT R. OOSTERVEEN**

I request and authorize Dr. _____ and/or such designees as may be selected by him/her to perform a **colonoscopy with possible biopsy or polypectomy** on:

_____

(Myself/Patient's Name)

together with such sedation and other treatments associated with the procedure, or which may be necessary or advisable to treat any complications which may arise during the procedure including control of bleeding, immediate treatment for perforation, or symptoms associated with medication allergies or responses**.** I understand during the course of the procedure unforeseen conditions may arise or be discovered which require the performance of additional procedures, and I hereby consent to the performance of such additional procedure(s) as my physician believes to be necessary or advisable.

I understand that sedative medications will be used to minimize the possibility of discomfort. Due to this sedation I understand I will be unable to drive for 24 hours following sedation and must have someone drive me home.

I recognize that the practice of medicine is not an exact science and I understand that no guarantees or promises have been made to me concerning the results of the procedure(s). I understand that colonoscopy is an accurate method of examining the large intestine, but there is an infrequent risk of misdiagnosis, missed lesions or misinterpretation of the results.

I authorize the Concord Endoscopy Center to dispose of or to retain tissue for diagnostic or therapeutic purposes. Images of the procedure may be stored in the patient's medical record. De-identified images of the procedure in which the identity of the patient will not be revealed may be collected for research.

I recognize that I may revoke this consent for treatment at any time before the procedure is performed, or any associated test, medication or treatment is administered.

I certify that I have read this consent and have been informed of the risks and possible complications of my procedure and of the sedation medications that may be used during my procedure. I am aware that in the event of a life-threatening emergency, Concord Endoscopy Center will perform any necessary emergency procedures and transfer me to the closest acute care facility (Concord Hospital). I understand that my medical information will become part of an electronic medical record managed by Concord Hospital and may be accessed by my primary care physician and medical personnel involved in my care.

**I hereby give my consent for the physician named above or his designee to perform the above named procedure:**

| _____ | _____ | _____ |
|---|---|---|
| **PATIENT OR LEGALLY AUTHORIZED SIGNATURE** | **WITNESS TO SIGNATURE** | **DATE & TIME** |

**PHYSICIAN SIGNATURE:** _____

CEC 10/04, 8/06, 5/08, 6/12, 7/14, 8/16, 12/16, 7/18,11/18

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**Concord Endoscopy Center**
**GI Associate of New Hampshire**
**Authorization Form**

Name

Date of Birth

Account Number

**I have received the following information related to my care at Concord Endoscopy Center:**

- **The Patient Bill of Rights**
- **Advanced Directives**
- **Notice of Privacy Practice, explaining how the Concord Endoscopy Center and the GI Associates of New Hampshire Office may use your personal health information**
- **The right to file a complaint and who to contact**
- **Concord Endoscopy Center Financial Disclosure**
- **Important Information About Your Procedure at the Concord Endoscopy Center**

I understand that Concord Endoscopy Center is not responsible for the loss of my personal possessions and that my personal belongings will remain with me on my stretcher while I am a patient in the Concord Endoscopy Center.

I agree to assign Concord Endoscopy Center, all insurance benefits otherwise payable to or on behalf of the undersigned for the referenced Concord Endoscopy procedure or subsequent services. I authorize Concord Endoscopy Center to release all medical information concerning such care to any potential/actual insurer or other payment source to the extent needed to determine liability and to discuss any bill or any issues relating to payment with said parties.

I know that I will pay the balance owed, if the insurance or personal information I have given is not true. I understand that the undersigned remains liable for all charges not covered by insurance or other benefits. I agree to pay Concord Endoscopy Center in accordance with its regular rates and terms for all services rendered to the named patient. All amounts are due immediately, upon receipt of the bill for said services. In the event that the bill is not paid pursuant to these terms and the account is placed with an attorney or agency for collection, I agree to pay actual attorney's fee and collection.

I authorize my physician and his/her designee in charge of my care to administer any treatment as deemed necessary or advisable in the diagnosis and treatment of my condition. I recognize I may revoke this request for treatment or any part of it, before a procedure, test, or medication is administered. I also recognize that I will participate in the planning of my care through verbal discussions with the Concord Endoscopy Center nursing staff and my physician.

**I prefer my laboratory specimens to go to:** ☐ **Concord Hospital** _____ (Pt. Initials) ☐ **Quest** _____ (Pt. Initials)

**I have had my questions answered and understand the above information.**

_____ _____
Patient/Legal Guardian/Guarantor Signature Date

_____ _____
Witness Signature Date

CONCORD HOSPITAL
250 Pleasant Street, Concord, NH 03301
(603)225-2711 **www.concordhospital.org**

# LABORATORY SERVICES
# TREATMENT AUTHORIZATION
# AND ADMINISTRATIVE ACKNOWLEDGMENT

AUTHORIZATION FOR LABORATORY SERVICES: I authorize Concord Hospital Laboratory to draw my blood, to accept urine and other specimens, to prepare and analyze specimens, and report results to my ordering physician or health care provider. I recognize that I may withdraw this authorization prior to having my blood drawn or providing urine or other specimens.

RISKS: Veins and arteries vary in size from one patient to another and from one side of the body to the other. Obtaining a blood sample from some people may be more difficult than from others.

Risks associated with having blood drawn include:

- Excessive bleeding from the puncture site
- Fainting or feeling light-headed
- Bruising (blood accumulating under the skin)
- Infection (a slight risk any time the skin is broken)
- Nerve damage
- Pain

ELECTRONIC MEDICAL RECORD ACKNOWLEDGMENT: Concord Hospital primarily uses electronic medical record systems to capture medical information in both the inpatient and outpatient settings. These systems allow my information to be available to my healthcare providers and the staff at Concord Hospital, Concord Hospital Medical Group practices, and other providers who are involved in my care, which would include my primary care provider, specialty care providers, consulting providers, on-call providers, emergency/urgent care providers, hospitalists and other hospital-based providers. Concord Hospital is committed to protecting my privacy in accordance with applicable state and federal laws. A complete description of how my health information may be used and disclosed is contained in the Concord Hospital Notice of Privacy Practices, available to me upon request.

HEALTH CARE EDUCATION: I acknowledge that Concord Hospital is a teaching institution, and health care workers in training are important members of my health care team. I understand that trainees, under appropriate supervision, may perform or observe some of the health care services that I receive. Additionally, I understand that students may perform certain services under appropriate supervision.

RECEIPT OF PATIENT INFORMATION: I acknowledge that I have been offered and/or provided a copy of the Patients' Bill of Rights.

MEDICARE/MEDICAID PATIENTS: I certify that the information given by me in applying for payment under Title XVIII (Medicare) and/or Title XIX (Medicaid) of the Social Security Act is correct. I authorize the Social Security Administration to release to Concord Hospital information pertaining to my Medicare entitlement. I authorize Concord Hospital to bill my Lifetime Reserve Days as necessary. I agree to pay for services not covered by Medicare or Medicaid.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS: I agree to assign to Concord Hospital, all insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. I agree that I am responsible to pay the balance owed if the insurance or personal information I have given is not true. I understand that I remain liable for all charges not covered by insurance or other benefits. I agree to pay Concord Hospital in accordance with its regular rates and terms for all services rendered.

Pursuant to NH RSA 151:12b when billing SELF-PAY patients, Concord Hospital accepts as payment in full an amount no greater than the amount generally billed and received by health carriers in a manner consistent with Section 9007 of the Patient Protection and Affordable Care Act of 2009. As such, uninsured patients will receive a discount off charges at the time of billing. Self-Pay Rates do not apply to insured patients for copayments, coinsurance, deductibles, or non-covered services.

All amounts are due immediately, upon receipt of the bill for said services. In the event that the bill is not paid pursuant to these terms and the account is placed with an attorney or agency for collection, I agree to pay actual attorney's fees and cost of collection.

I understand that if I am presenting with a work-related injury, it is my responsibility to provide Concord Hospital with accurate information regarding my employer and my workers' compensation insurance. I further understand that I remain liable for all charges not covered by workers' compensation, health insurance, or other benefits.

PHONE COMMUNICATION: I consent to receive calls to the cellular and residential telephone numbers I have provided, including calls using any type of artificial or prerecorded voice or auto-dialer technologies made by or on behalf of the Hospital, its providers, assignees, agents, servicers, debt collectors, or any owner of a receivable for unpaid services or treatment provided to me by the Hospital or any of its providers.

I have read and fully understand the information above. I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the conditions described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions on behalf of the patient.

Sign Here _____ _____

Patient/Legal Guardian/Appropriate Authorizing Party Witness signature

Date _____ Time _____

Date Time

_____

Print name and relationship to patient

Patient is unable to personally authorize because: _____

Concord Imaging Center

248 Pleasant Street Suite 102
Concord, NH 03301
(603) 225-0425 fax (603) 224-9933

60 Commercial Street Suite 101
Concord, NH 03301
(603) 415-9444 fax (603) 415-9440

1990 Dover Road
Epsom, NH 03234
(603) 736-6235 fax (603) 736-4318

# TREATMENT AUTHORIZATION AND ADMINISTRATIVE ACKNOWLEDGMENT

AUTHORIZATION FOR TREATMENT: I authorize my provider(s) or his/her designee(s) or consultant(s), in charge of my care at Concord Imaging Center (CIC), to provide services deemed necessary or advisable in the diagnosis and treatment of my condition. I understand that I may withdraw this authorization for treatment at any time before a procedure, test, or medication is administered.

In cases of emergency, I understand that the need for prompt medical attention may prevent authorization of a more detailed or specific nature before proceeding. In this circumstance, I authorize my provider(s) and their designee(s) to administer such anesthetics and perform such operation and procedures, as they deem necessary. Any tissues or parts surgically removed may be disposed of by CIC in accordance with the customary practice.

I agree that CIC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

ELECTRONIC MEDICAL RECORD ACKNOWLEDGMENT: Concord Imaging Center(CIC) primarily uses electronic medical record systems to capture medical information in the outpatient setting. These systems allow my information to be available to my healthcare providers and the staff at CIC, Concord Hospital Medical Group practices, and other providers who are involved in my care, which would include my primary care provider, specialty care providers, consulting providers, on-call providers, emergency/urgent care providers, hospitalists and other hospital-based providers. CIC is committed to protecting my privacy in accordance with applicable state and federal laws. A complete description of how my health information may be used and disclosed is contained in the Notice of Privacy Practices, available to me upon request.

HEALTH CARE EDUCATION: I acknowledge that CIC is a teaching institution, and health care workers in training are important members of my health care team. I understand that trainees, under appropriate supervision, may perform or observe some of the health care services that I receive. Additionally, I understand that students may perform certain services under appropriate supervision.

PERSONAL VALUABLES: I understand that CIC is not responsible for my personal possessions. If I choose to keep personal belongings, I may request that these items be stored in a locker.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS: I agree to assign to CIC, all insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. I agree that I am responsible to pay the balance owed if the insurance or personal information I have given is not true. I understand that I remain liable for all charges not covered by insurance or other benefits. I agree to pay CIC in accordance with its regular rates and terms for all services rendered. I grant permission to my treating providers to release my medical records for the purpose of claims adjudication.

All amounts are due immediately, upon receipt of the bill for said services. In the event that the bill is not paid pursuant to these terms and the account is placed with an attorney or agency for collection, I agree to pay actual attorney's fees and cost of collection.

I understand that if I am presenting with a work-related injury, it is my responsibility to provide CIC with accurate information regarding my employer and my workers' compensation insurance. I further understand that I remain liable for all charges not covered by workers' compensation, health insurance, or other benefits.

PHONE COMMUNICATION: I consent to receive calls to the cellular and residential telephone numbers I have provided, including calls using any type of artificial or prerecorded voice or auto-dialer technologies made by or on behalf of CIC, its providers, assignees, agents, servicers, debt collectors, or any owner of a receivable for unpaid services or treatment provided to me by CIC or any of its providers.

By signing below I acknowledge that I understand and agree to the terms set forth above.

Sign Here _____ _____

Patient/Legal Guardian/Appropriate Authorizing Party Witness signature

Date _____ Time _____

Date Time

_____

Print name and relationship to patient

Patient is unable to personally authorize because: _____

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