Front Range Preventive Imaging

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. 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: _____TIME: _____

Before you start this "Prep", you must purchase:

ONE (1) - Bottle of MAGNESIUM CITRATE
(or Citrate of Magnesia, or Citrate of Magnesium)
10 FL. OZ (296mL) (Liquid form only)

- **Available in all drug stores, grocery stores**
- **Any brand is fine**
- **Any flavor or color is okay**
- **MUST be 10 oz. liquid.**

(Example only. Any brand, any flavor, or plain is fine)

2880 Folsom, Suite 100, 303-443-7226

VC PREP EASY CHECK LIST

DATE: _____ (Two Days Before Procedure)

- □ 1. Regular meals all day
- □ 2. Morning: Mix 1st Miralax packet with 1 cup of any beverage & then drink.
- □ 3. Lunch: Mix EZ-Cat Barium packet with 2 cups water – Drink 1 cup at lunch
- □ 4. Evening: Drink remaining 1 cup of the EZ-Cat Barium with dinner
- □ 5. Evening: Mix 2nd Miralax packet with 1 cup of any beverage & then drink.
- □ 6. Put suppository in refrigerator.
- □ 7. **Purchase 10 oz. bottle of Magnesium Citrate, any brand, any flavor**

DATE: _____ (Day Before Procedure)

Do You Have Your 10 oz. Bottle of Magnesium Citrate? You NEED it TONIGHT!!!!

- □ 1. Morning: Plain scrambled eggs or some cheese in the morning if you cannot go all day with liquids only. Do not eat anything solid after this.
- □ 2. No solid food the rest of the day. Drink any clear liquid. Drink a minimum of 64-80 ounces or more throughout the day.
- □ 3. Morning: Mix 3rd Miralax packet with 1 cup of any beverage & then drink.
- □ 4. Morning: Mix EZ-Cat Barium packet with 2 cups water – Drink 1 cup now
- □ 5. Lunch: Mix 4th Miralax packet with 1 cup of any beverage & then drink.
- □ 6. Lunch: Drink remaining 1 cup EZ-Cat Barium now.
- □ 7. Approx. 5:30 pm: Drink the entire 10 oz. bottle of Magnesium Citrate Oral Solution.
- □ 8. Next 2 Hours: Drink at least 3 glasses of any clear liquid.
- □ 9. Approx. 7:30 pm: Take 4 orange Biscodyl Tablets with 8 ounces clear liquid.

DATE: _____ (Day of Procedure)

- □ 1. Insert suppository at 6:00 am. (or 2 hours before your exam, allowing for drive time)
- □ 2. DO NOT eat or drink anything until after your exam.

If you have any questions, regardless of day or time of day, Please call Lindsay at 970-481-2944

Two Days Before Your Exam

Follow your normal meal routine the entire day. In the morning mix the **1st *MiraLax*** packet with 1 cup of any beverage and then drink. In the afternoon mix the **2nd MiraLax** packet with 1 cup of any beverage and drink.

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.**

Please place the **Bisacodyl Suppository** in the refrigerator until the morning of your exam. **Buy a 10 oz bottle of liquid Magnesium Citrate, or Citrate of Magnesia, any brand any flavor. MUST BE 10 oz.LIQUID. Available at any grocery store or drug store.**

The Day Before Your Exam
In the morning mix the **3rd MiraLax** packet with 1 cup of any clear beverage and then drink. Mix and drink the **4th MiraLax** packet in the afternoon.

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.**

Friendly Reminder: Make SURE you have the 10 oz. bottle of Magnesium Citrate!

All Day: Ideally, 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), **Gatorade**, carbonated or noncarbonated soft drinks, Kool-aid and ice Popsicles, plain Jell-O, (Jello without fruit or topping). Drink plenty of fluid throughout the day to avoid dehydration. If you must eat something, you may have plain scrambled eggs or cheese in the morning only. Then liquids only for the rest of the day and evening.

Approx. 5:30 pm – Drink the entire 10 oz. of the Magnesium Citrate oral Solution. This product usually produces a bowel movement in 6 minutes to 12 hours. Drink at least 3 more glasses of clear liquids within the next 2 hours.

Approx. 7:30 pm – (2 hours after drinking the Magnesium Citrate) Remove the 4 Bisacodyl tablets and take with 8 ounces of clear liquid. These tablets generally produce bowel movements in 6 to 12 hours.

Ensure that you have easy access to a restroom. Individual responses to laxatives vary. 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.

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, try for at least 15 minutes. Bowel evacuation usually occurs within 15 to 60 minutes. This is to help eliminate any residual gas or fecal material in the lower portion of the colon. **DO NOT EAT OR DRINK ANYTHING UNTIL AFTER YOUR EXAM.**

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

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: Friend Radio Newspaper
Website Newsletter Other _____

Physician: _____

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:_____

***Print Name*_____ *DATE*_____**

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

Colonoscopy __when ___Polyp biopsy/removal __when___

Barium Enema _____when _____other ____when_____

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: _____

_____

Smoking History Former No Current
If you smoke: Packs/ day _____ Years smoking _____

***Print Name*_____ *DATE*_____**

Front Range Preventive Imaging

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 approximately 5 mSv of radiation during the procedure.
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 CO_2 in order to help visualize 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, is there any chance you may be pregnant?
   YES NO (please circle one) **Technologist Initials_____**

Are you: (circle one) Self referred or physician referred

Would you like a copy to go to a medical provider YES NO
If YES please provide the following:

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:_____

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

Boulder Internal Medicine
and
Front Range Preventive Imaging

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 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 Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities.

Obtain an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may refuse your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will agree to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

We do not engage in fundraising nor will we ever sell your information for any purpose.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

We are allowed or sometimes required to share your information in other ways – usually in ways that contribute to the public good, such as for public health and research. We have to meet many conditions in the law before we can share your information for these following purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Health Information Exchange

We endorse, support, and participate in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and healthcare providers that participate in the HIE network. Using HIE helps your healthcare providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your healthcare providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site

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