

## **BWH Department of Radiology CT Colonography Screening Program Waiver**

Insurance Coverage Advisory prior to rendering radiological services for CT Colonography

Welcome to Brigham and Women's Hospital Department of Radiology CT Colonography Screening program. You are scheduled to receive a CT Colonography Screening, which means you are experiencing no health problems related to the radiology services you will receive. If this is not accurate, please inform us of your symptoms at once.

Although CT Colonography has been shown in several studies to be effective in certain patient groups, insufficient studies have been performed to document its accuracy in a screening population. CT Colonography is best suited for patients who are unable or unwilling to undergo conventional Colonoscopy. Although the experience with this test is promising, the precise role of CT Colonography has not been established, particularly for polyps and cancers less than 1cm. The radiation dose for this exam is about 40% of a typical CT of the abdomen and pelvis. When clinically feasible, standard Colonoscopy is the optimal screening tool. As a result, this waiver (or an ABN for Medicare patients) must be signed. **The cost of the exam is \$899.** You will receive 2 bills, one from the Brigham and Women's Physician's Organization (\$299) and one from the hospital (\$600).

**Insurance information:** Your insurance has established rules for paying for health care services. The radiology service that you are receiving today will most likely **not** meet the coverage requirements of your insurance program and your insurer likely will not pay for these services. As a result, you will be held financially responsible for payment of your CT Colonography Screening.

**Patient Release and Waiver:** Your signature below denotes that you have read this notice and understand and accept this financial responsibility.

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Signature of Patient or Person acting in their behalf

Date

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Please print full name

**Release of Information:** Please provided the **name, address and phone number** of your primary care, or other physician responsible for coordinating your care, where you would like the results of today's test sent.

Name:

Address:

Phone: