GASTRO HEALTH

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You are scheduled for a Small Intestinal Bacterial Overgrowth Breath Test on:_____ at: _____ in Suite 110

****A $50.00 cancellation fee will be billed directly to the patient for any appointment not cancelled with a 48 hour notice.****

This test is used to determine if bacteria have invaded the small intestine either from the stomach, where they are usually killed by stomach acid, or from the large intestine, where they are normally found and are necessary for normal intestinal function. Bacteria in the colon (large intestine) break down complex sugars and release hydrogen, methane and carbon dioxide. Some of the gases are reabsorbed into the blood stream and are brought to the lungs, where they are exhaled with your breath. The time at which these trace gases are detected in the lung air after the ingestion of a dose of a special sugar, glucose, can be used to estimate where the bacteria are located in the intestinal tract. If trace gases appear early on in the test, it means that the bacteria must exist toward the stomach. If trace gases appear only later in the test, the bacteria must reside in the colon only.

PREPARATION for the test:

1. If tolerated, stop medications such as: Miralax, Dulcolax, Docusate, Amitiza, Linzess, Milk of Magnesia, Stool Softners, Digestive Enzymes, Lactase, Metoclopramide, Domperidone **AND ALL OTHER LAXATIVES AND PROMOTILITY MEDICATION** 1 week prior to the test. Please call the office if you have questions.

2. No high-fiber or slowly digesting foods the day before the test. For example: bran, coarse breads, nuts, seeds, beans, fruits, dairy products or vegetables.

3. Liquids only for dinner the night before the test (4hours before fasting time starts). Allowed liquids are chicken broth, beef broth and water.

4. No food, liquids, medication, gum, breath mints and hard candy for at least 12 hours before the test. You may only have sips of water to drink.

5. On the day of the test you may brush your teeth making sure you do not swallow toothpaste. Please do not use mouth wash.

6. No smoking at least 1/2 hour before the test.

7. No sleeping or vigorous exercising for at least one hour before, or during the test.

8. No antibiotics or probiotics such as Align, Florastor and etc. for 4 weeks prior to the test. Notify (or remind) the Doctor or Nurse Practitioner of any recent antibiotic treatment and/or runny diarrhea.

When you come in for the test, you will be asked to drink a sugar-water solution. Samples will then be taken of your exhaled breath at intervals. As comparison, a breath sample will be taken before you drink the solution. The procedure is simple and painless; it involves no needles. The entire test requires several samples taken over a period of 3 hours. During this time, you may engage in quiet activity while waiting between samples. No food or liquids may be eaten during the test.

Gastro Health

ADVANCE BENEFICIARY NOTICE

NOTE: You need to make a choice about receiving these health care items or services.

Your health insurance may not pay for the services that are described below. The fact that your insurance may not pay for a particular service does not mean that you should not receive it. There may be a good reason for your doctor recommending it.

Services:

- **_____ Small Bowel Capsule Endoscopy – Code 91110 - $2500.00**
- **__X___ SIBO/Glucose Breath Test/KBT – Code 91065 - $300.00**
- **_____ Lactose Breath Test – Code 91065 - $300.00**
- **_____ Fructose Breath Test – Code 91065 - $300.00**
- **_____ Urea Breath Test – H.Pylori – Code 78267 - $150.00 – acquisition**
  - **Code 78268 - $300.00 – analysis**
  - **Total $450.00**
- **_____ Fibroscan – Code 91200 - $150.00**

Diagnosis:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you might have to pay for them yourself.

You may wish to contact your insurance company directly and give them the information as outlined above regarding the service. The description of the service, the procedure code which will be billed, as well as the fee that would be charged may be given to them for prior approval.

The office will submit the claim to your health insurance. You will, however, be fully and personally responsible for payment of this service if the insurance company denies payment. **No appointment will be made without this signed authorization.**

I want to receive these services. I agree to pay personally for any services denied by my insurance carrier.

_____ _____

Date **Signature of Patient**