Associates in Gastroenterology

To Our Patients,

We thank you for choosing our practice for your gastrointestinal medical care. We are looking forward to providing to you the highest quality of care.

Our practice is compliant with all of the Medicare and national guidelines including electronic medical record, electronic prescriptions and identity theft compliance. We have enclosed for you some forms to complete prior to your appointment time. Completing this paperwork prior to your visit will help us to better evaluate your needs and to serve you in a more timely fashion.

You will need to bring with you at the time of your appointment:

- Completed forms,
- Your insurance cards
- A photo ID
- All of your current medications

If you have questions regarding the completion of the forms please feel free to contact our office at the above address and number. Thank you for your cooperation.

Sincerely,

The Physicians and Staff
Associates in Gastroenterology

Associates in Gastroenterology
Patient Information Form

Patient Information

Last Name_______________________________ First Name________________________ M.I._____ Circle: M / F

Race: [ ] Caucasion [ ] African-American [ ] Other ___________________________________

Social Security Number_____________________ Date of Birth_______________ Are you a full time student: Yes ______ No ____

Address_____________________________________ City_______________ State_______ Zip ___________

Home Phone____________________ Work Phone______________________ Cell Phone ________________

Employer Name and Address ____

E-mail Address____

Spouse Information

Last Name_____________________________ First Name_____________________________ M.I.________

Social Security Number____________________________ Date of Birth_______________________________

Home Phone____________________ Work Phone______________________ Cell Phone ________________

Employer Name and Address____

Complete the section below regarding person responsible for insurance coverage:

Primary Coverage: Insurance Name ____

Last Name ____________________First Name______________________ M.I._____

Secondary Coverage: Insurance Name ____

Last Name____________________ First Name______________________ M.I._____

Name of person to contact in the case of an emergency other than spouse:

Name____ Relationship_______________ Phone#___________________________

Do you have a pharmacy of choice? (List name and Location)____

How did you hear of our practice? [ ] Newspaper Article / Ad [ ] Family Member/ Friend

[ ] Physician __________________ [ ] Internet / Website/ Google

Name of your primary care physician: ____

I hereby authorize payment of medical benefits billed to my insurance to Associates in Gastroenterology, PLC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceeds the payment made by my insurance, if the Practice does not participate with my insurance. I understand that in the event of default in the payment of any amount due and if this account is placed in the hands of a collection agency or attorney for collection or legal action an additional charge equal to the cost of collection, including the collection agency and attorney fees and any court cost incurred.

I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered. I agree that any overpayment on this account will be automatically transferred to any balance due for the Hermitage TN Endoscopy facility charge prior to a refund being given to me.
I also hereby authorize Associates in Gastroenterology LLC to leave information or message regarding my care at my home phone number including voice mail or answering service devices.

____ _______________________

Signature of patient or guardian *date*

Please turn page over

Associates in Gastroenterology

[This form is required by the federal government]

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ________________________________ , hereby authorize **Associates in Gastroenterology, PLC** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Associates in Gastroenterology, PLC** can refuse to treat me.

I have been informed that **Associates in Gastroenterology, PLC** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I have been given a copy of this notice

I understand that I may revoke this consent at any time by notifying **Associates in Gastroenterology, PLC**, in writing, but if I revoke my consent, such revocation will not affect any actions that **Associates in Gastroenterology, PLC** took before receiving my revocation.

I understand that **Associates in Gastroenterology, PLC** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Associates in Gastroenterology, PLC** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Associates in Gastroenterology, PLC** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Associates in Gastroenterology, PLC** must adhere to such restrictions.

HIPAA Privacy Notice / Patient Rights / Advanced Directive

I hereby acknowledge that a copy of the Notice of Privacy Practices for **Associates in Gastroenterology, PLC** has been made available to me. I have the right to obtain a paper copy upon request.

I have received written and verbal notification regarding my Patient rights prior to my procedure. I have also received information regarding **Associates in Gastroenterology, PLC** policies pertaining to advanced directives. Advanced Directives will not be honored within this office.

____ ______________

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

____

Printed name of patient or patient's representative

____

Relationship to the patient

Release of Medical and Billing Information

I, ________________________, authorize the physicians and staff of Associates in Gastroenterology, PLC to release information on file regarding my medical treatment and my medical billing account to the persons listed below:

Name ____ Relationship ________________________________

Name ____ Relationship ________________________________

Name ____ Relationship ________________________________

I understand that by signing this release that designated person(s) above will be able to speak to any member of the medical staff. Furthermore, I understand that these medical practices cannot be held liable for any information the above stated person(s) may obtain regarding my medical and billing information.

Signature of Patient / Guardian ____________________________________ Date ______________________________

Witness Signature ____ Date ______________________________

Associates in Gastroenterology Patient Health Information Form

(This form will be included as part of your medical record)

Patient Name: ____ **Date:** ______________

SS# …-..- ___________ **Date of Birth** ____________________ **Age** _________ **Ethnicity:** ______________________________

Referring Physician: ______________________________________ **Primary Care Physician:** ______________________________________

Pharmacy: ____ **Pharmacy Location/ Phone#** ______________________________________

(All new prescriptions and refill prescriptions will be submitted electronically to your designated pharmacy)

What is the reason you are here today?____

____

Are you over the age of 45? _____YES _____NO To your knowledge have you ever been tested for Hepatitis C virus ? _____YES _____NO

Have you had any of the following regarding this problem: (Circle all that apply)

Blood Test, CT Scan, MRI, Ultra-sound, X-ray, Medication: ________________________________

Other____

***Chief Complaint*: What are your current symptoms: (Check All That Apply)**

	Yes	No		Yes	No		Yes	No		Yes	No
Abdominal Pain			Weight Loss			Alterations of bowel habits			Night Sweats		
Heartburn			Loss of appetite			Black tarry stools			Cough		
Indigestion			Bloating/ Flatulence			Rectal bleeding			Food Intolerance		
Difficulty swallowing			Excessive Gas			Hoarseness			Fever		
Painful swallowing			Constipation			Sore throat					
Nausea / vomiting			Diarrhea			Fatigue					

Your Past Medical History **(Check All That Apply)**

	Yes	No		Yes	No		Yes	No		Yes	No
Diverticulosis			Hepatitis			Anemia			Bleeding tendencies		
Irritable bowel/ spastic colon			Pancreatitis			Shortness of Breath			High Cholesterol		
Colonic or Gastric Polyps			Cirrhosis			Asthma			Hypothyroidism		
Colon Cancer			Liver disease			Emphysema			Diabetes		
Ulcerative Colitis			Breast Cancer			Positive TB skin test			Kidney Problems		
Other Colitis			Prostate Cancer			Coronary Artery Disease			Urinary Problems		
Ulcer Disease			Liver Cancer			Heart Attack			Anxiety/ Depressio		
Sleep Apnea/ CPAP Usage			Other Cancer Type______________			High Blood Pressure			Other___________		

Your Past Surgical History: (Check All That Apply)

	Colonoscopy	**Colon Resection**	**EGD**	**ERCP**	**Aneurysm Repair**	**Gallbladder**	**Gastric Bypass**	**Hysterectomy**	**Joint Replacement**	**Heart Valve Replacement**	**Heart Surgery**	**Spleen Removal**	**Trouble with anesthesia**
Yes													
No													

FAMILY HISTORY (Check All that Apply

	Colon Cancer	Other Cancer	Colonic or Gastric Polyps	Crohns	Ulcerative Colitis	Hepatitis	Hiatal Hernia	Irritable Bowel	Pancreatic Disease	Liver Disease	Ulcers	Coronary Artery	Heart Attack	High Blood Pressure	Diabetes
Mother															
Father															
Brother															
Sister															
Son															
Daughter															
Maternal Grandparent															
Paternal Grandparent															

Medications: **(List All Prescription and Over the Counter Medications that you are currently taking)**

Name of Medication	**Reason for taking medication**	**Dosage**	**Directions for taking**
Do you take aspirin daily? Yes / No			

Are you allergic to:	**Yes**	**No**	**Reaction**
Penicillin			
Sulfa			
Antibiotic			
X-Ray Dye			
Sedatives			
Other			

Social History: (Check All That Apply)

Tobacco Use: None 1 pk/day ______ 1+pk/day______ Year Stopped____
Alcohol Use: None Social 1/day 2-3/day 4+day Year Stopped____
Caffeine Use: Coffee_____cups/day Tea_____/day Cola Drinks_____/day
Street Drugs: Never_____ In the past_____ Occasionally_____ Frequently_____

I understand this form will be kept as a part of my medical record.
Patient Signature: ____