GASTROENTEROLOGY ASSOCIATES, PC

PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Referring Doctor: _____

REASON FOR VISIT: _____

Drug Allergies: _____**Reactions:** _____

Current Medications: _____

_____

Are you on: Blood thinner? _____If yes, name? _____ Aspirin? _____ Anti-inflammatories: _____

PAST OR PRESENT MEDICAL CONDITIONS ( ) NONE

( ) Atrial fibrillation	( ) Fibromyalgia	( ) Angina/Heart Attack	( ) Asthma	( ) Anxiety
( ) Alcoholism	( ) Diverticulosis	( ) Heart Failure	( ) Seasonal Allergies	( ) Depression
( ) Anemia	( ) GERD	( ) Heart Valve Disease	( ) Lung Disease	( ) Bipolar Disorder
( ) Barrett's Esophagus	( ) Hepatitis	( ) Hypertension (high blood pressure)	( ) Emphysema/COPD	( ) STD
( ) Colitis	( ) Liver Disease	( ) Stroke	( ) Sleep Apnea	( ) HIV
( ) Colon Cancer	( ) Peptic Ulcer Disease	( ) Diabetes	( ) Arthritis	( ) Glaucoma
( ) Colonic Polyps	( ) Bladder Disease	( ) Kidney Disease	( ) High cholesterol	( ) Seizures/Epilepsy
( ) Crohn's Disease	( ) Thyroid Disease	( ) Mitral Valve prolapse		

OTHER CONDITIONS: _____

PREVIOUS SURGERIES ( ) NONE

( ) Abdominal Surgery	( ) Appendectomy	( ) Cholecystectomy(gallbladder)	( ) C-Section	( ) Gastric Bypass
When: _____	When: _____	When: _____	When: _____	When: _____
Where: _____	Where: _____	Where: _____	Where: _____	Where: _____
( ) Heart Surgery/ Stent	( ) Hernia Surgery	( ) Partial Hysterectomy	( ) Total Hysterectomy	( ) Vascular Surgery
Pacemaker/Defibrillator	When: _____	When: _____	When: _____	When: _____
When: _____	Where: _____	Where: _____	Where: _____	Where: _____
Where: _____	( ) **Other Surgeries**: _____			

PREVIOUS PROCEDURES ( ) NONE

( ) Colonoscopy	( ) Gastroscopy	( ) Flexible Sigmoidoscopy	( ) Other: _____
When: _____	When: _____	When: _____	When: _____
Where: _____	Where: _____	Where: _____	Where: _____

IMMUNIZATIONS ( ) NONE

( ) Hepatitis B	( ) Hepatitis A	( ) Influenza (flu)	( ) COVID	( ) COVID Booster	( ) Shingles	( ) Pneumonia
When:__/__/___	When: __/__/___	When: __/__/___	When: __/__/___	When: __/__/___	When: __/__/____	When: __/__/____

HAS ANYONE IN YOUR FAMILY HAD ( ) NONE

( ) Celiac Disease	( ) Crohn's Disease	( ) Colon Cancer	( ) Colonic Polyps
Relationship: _____	Relationship: _____	Relationship: _____	Relationship: _____
( ) Stomach Cancer	( ) Gallstones	( ) Ulcerative Colitis	( ) Other:
Relationship: _____	Relationship: _____	Relationship: _____	Relationship: _____

SOCIAL HISTORY

Occupation: _____ Number of Children: _____

( ) Exercise ( ) None	( ) Alcohol ( ) None	( ) Tobacco ( )Never smoked	( ) Drugs ( ) None
Type: _____	( ) Beer ( ) Wine ( ) Liquor	( ) Current every day smoker	( ) Marijuana ( ) Heroin
How Often: _____	How often: _____	( ) Current some day smoker	( ) Cocaine ( ) LSD ( ) Crack
	How many: _____	( ) Former smoker	How often: _____

IBD Patients only: SCREENINGS: Cervical Cancer date_____ Skin Cancer date _____Dexa Scan date _____
IMMUNIZATIONS: MMR_____Tetanus_____ Herpes Zoster_____HPV_____RSV_____

Patient Name: _____ Date of Birth: _____

Pharmacy Name and Address: _____

We have the ability to import your current medication list from the pharmacy, if you do NOT want us to have this option, check here ☐

Review of Systems: Please ***CHECK*** only if you are having any of the following symptoms:

Constitutional	**Allergy**	**Musculoskeletal**
( ) Fever ( ) Chills ( ) Weight loss ( ) Fatigue/malaise	( ) Environmental allergies	( ) Back or neck pain ( ) Falls ( ) Joint pain ( ) Muscle pain/cramping
Cardiovascular (Heart)	**Gastrointestinal (Stomach)**	**Neurological (Nerves)**
( ) Chest Pain ( ) Leg Swelling ( ) Palpitations /fluttering of heart ( ) Shortness of breath while exercising ( ) Shortness of breath while lying down or during sleep	( ) Abdominal pain ( ) Constipation ( ) Diarrhea ( ) Heartburn ( ) Nausea ( ) Vomiting ( ) Difficult or painful swallowing ( ) Rectal bleeding ( ) Black stools	( ) Abnormal movements or tremor ( ) Dizziness / vertigo ( ) Fainting ( ) Headaches ( ) Seizures ( ) Tingling or other sensory changes ( ) Weakness
Head/Eyes / Ears / Nose / Throat	**Genitourinary**	**Psychiatric**
( ) Blurred vision ( ) Eye irritation from light ( ) Eye redness ( ) Eye pain ( ) Nasal congestion ( ) Post Nasal Drip ( ) Nosebleeds ( ) Sore throat ( ) Sores in mouth ( ) Ear pain or hearing loss	( ) Hesitation/difficulty when urinating ( ) Pain when urinating ( ) Frequent or urgent urination ( ) Blood in urine	( ) Anxiety ( ) Depression ( ) Loss of sleep ( ) Memory loss ( ) Situational Stress ( ) Substance abuse ( ) Suicidal ideas
Hematologic	**Integumentary (Skin)**	
( ) Easy bleeding/bruising ( ) Night sweats	( ) Itchiness ( ) Rash	
Endocrine	**Respiratory (Lungs)**	
( ) Cold intolerance ( ) Hair loss / growth ( ) Heat intolerance ( ) Hot flashes	( ) Cough ( ) Shortness of breath ( ) Wheezing	

GASTROENTEROLOGY ASSOCIATES, PC

PATIENT INFORMATION FORM

DATE: _____

NAME: _____ GENDER: _____

BIRTH DATE: _____ SOCIAL SECURITY #_____

MAILING ADDRESS: _____

_____

E-MAIL ADDRESS: _____

THE FOLLOWING ARE THE NUMBERS WHERE I CAN BE REACHED WITH INFORMATION REGARDING MY APPOINTMENTS, MEDICAL CARE, TREATMENTS, AND/OR TEST RESULTS:

CELL PHONE: _____ You MAY NOT send a text ☐	**HOME PHONE: _____**	**WORK PHONE: _____**

Name of Primary Care Physician: _____

Name of Referring Physician: _____

****

EMPLOYER: _____ADDRESS: _____

(Parent's if patient is a minor)

PARENT/GUARDIAN NAME & S.S. #_____

EMERGENCY CONTACT: _____PHONE: _____

MARTIAL STATUS: ☐ Single ☐ Married ☐ Widow(er) ☐ Student

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other _____

RACE: ☐ White/Caucasian ☐ African American ☐ Spanish/Hispanic ☐ Asian ☐ Other _____

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other _____

SPOUSE: Name: _____ Employer: _____ Work #: _____

****

INSURANCE INFORMATION: PLEASE ALLOW US TO PHOTOCOPY YOUR INSURANCE CARD(S)

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

PRIMARY INSURANCE: _____ Policy ID #: _____Group #: _____

SECONDARY INSURANCE: _____ Policy ID #: _____Group #: _____

Insured's Name if Other Than Self: _____ Insured's Date of birth: _____

Insured's Address if Different Than Above: _____

Insured's SS# _____ Insured: ☐ Male ☐ Female

GASTROENTEROLOGY ASSOCIATES, PC

Privacy Practices Acknowledgement

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. We also want you to know that we support your full access to your personal medical record. You may refuse to consent to the use or disclosure of your PHI, including third party vendors, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Protected Health Information (PHI). You may not revoke actions that have already been taken, however. I acknowledge that I can ask for the full Notice of Privacy Practices of Gastroenterology Associates, P.C. and have the opportunity to ask questions about the information provided in the notice and that I may request a paper copy of the notice.

I consent to treatment by GASTROENTEROLOGY ASSOCIATES, P.C., and to the use and disclosure of my PHI. I understand this includes:

* conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment, directly or indirectly
* obtain payment from insurance companies
* conduct normal healthcare operations such as quality assessments

I understand that I have certain rights to privacy regarding my PHI. I understand that I may request in writing that you restrict how my protected health information is used or disclosed. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship

I hereby give my permission to the person(s) listed below to receive verbal information about my care and treatment.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

TELEMEDICINE PROGRAM

TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian) _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a provider and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

_____ _____

Signature of patient or patient's representative Date

GASTROENTEROLOGY ASSOCIATES, PC
FINANCIAL POLICY

Patients with insurance:

- The providers' office will bill insurance plans as a courtesy to their patients if the patient provides the required insurance information at the time of service. **Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are patient's responsibility from the date the services are rendered.**
- It is the patient's responsibility to determine whether a referral is required, and the referral can be requested from your primary care physician. If the patient is unable to obtain the referral at the time of the visit, he/she will have the option of paying for the visit or rescheduling.
- If the patient's insurance denies coverage, or only provides partial coverage, the patient shall be responsible for immediate payment of the balance due. A pre-treatment deposit may be required.

Patients without insurance:

- All charges are due and payable at the time of service. We accept cash, check, and major credit cards.

No-Show and Cancellation Policy:

- If the patient fails to cancel his/her procedure at least 3 business days in advance or fails to show up for the scheduled procedure, the patient will be charged a **$200 fee**, which must be paid upon receipt.*
- If the patient fails to cancel his/her clinic or virtual appointment at least 1 business day in advance or fails to show up for the scheduled visit, the patient will be charged for a **$50 fee**, which must be paid upon receipt.*

***These charges may not be applied to any copay, deductible or coinsurance.**

Delinquent / Unpaid Account:

- Prior to providing services, payment of prior outstanding accounts will be requested and must be paid. Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment.
- Accounts which cannot be collected by the provider's office after normal in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action in accordance with the established guidelines. All delinquent accounts over 90 days will incur a service fee of $20. Accounts referred to collection agency will be subject to a 25% fee. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within (30) thirty days of billing.

Refunds:

- Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patient's refunds will not be processed until all active or past due accounts are paid in full.

Returned Checks:

- Checks returned to Gastroenterology Associates, PC for insufficient funds, closed account, stopped payment, or any other reason will be subject to a $50 fee.

I, the patient/patient legal representative, understand and agree to abide by the financial policy set forth.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship

GASTROENTEROLOGY ASSOCIATES, PC
PATIENT RIGHTS AND RESPONSIBILITIES

As a patient, you have a right to:

- Considerate and respectful medical care provided in a safe environment, free from harassment or discrimination.
- Be informed about your illness, treatments, and plan of care, and freely discuss all aspects of your medical care with your physician or advanced practitioner.
- Participate in the implementation of your plan of care and make decisions, including the right to refuse treatment to the extent that is allowed by law.
- Privacy of your medical information and confidentiality of your records unless you have given permission to release information or if reporting is permitted or required by law.
- Request a second opinion or change physicians.
- Be made aware of our fee for services and payment policies.
- Express grievances regarding any violation of patient rights or concerns about your medical care.

As a patient, you are responsible for:

- Providing complete and accurate information about your medical history, as well as billing, insurance, and all other information that is requested.
- Keeping appointments and notifying the practice when you are unable to do so. (Please see our Financial Policy)
- Following treatment plan developed for you and letting your physician or advanced practitioner know if you cannot follow through with it, understanding the possible results of not following recommended treatment plan.
- Being respectful toward medical providers, office staff, and other patients.
- Understanding that use of foul language, threatening tone, shouting, and any form of sexual harassment and/ or inappropriate physical contact will not be tolerated. Any form of violent or inappropriate behavior including but not limited to those examples listed will result in the patient's immediate dismissal from the practice.

I, the patient/patient legal representative, understand and agree to abide by the rights and responsibilities set forth.

_____ _____

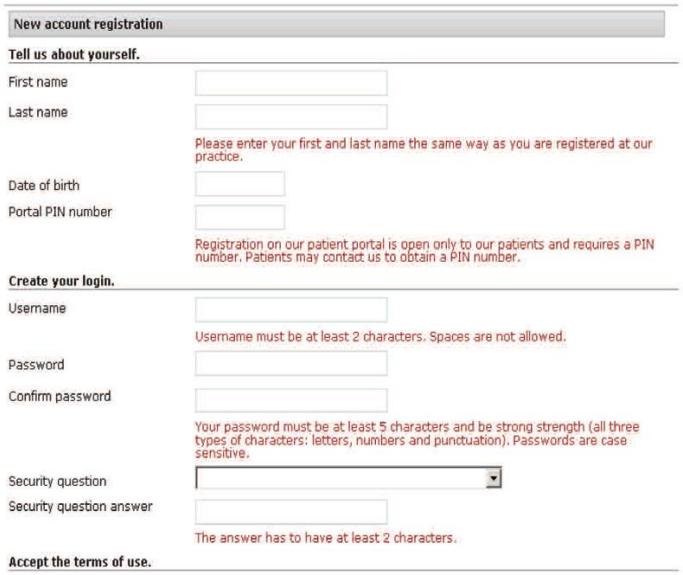
Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship

Sign up for our Patient Portal today!

Step 1: You will receive an invitation email from our practice with a link and a unique ID that will take you through the registration process. (Make sure to give us your email at your visit and contact our staff if you do not receive an invitation)
Step 2: Click on the link in the invitation email to create a unique user ID and password.



Step 3: Click on the messages tab on the left side of the page. Click “New Messages”. Send your first message to the practice saying you are signed up and this will complete the registration process.

Now you are all registered for the portal and can do the following:

- **Review your results**
- **Send messages to your provider**
- **Request appointments**
- **Pay your medical bill**
- **Review & Print your medical records**

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