ADVANCED DIGESTIVE CARE, LLC/ GASTROENTEROLOGY ASSOCIATES

PATIENT HISTORY

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

Referring Doctor: _____

CHIEF COMPLAINT: _____

Drug Allergies: _____ **Reactions:** _____

Current Medications: _____

_____

Are you on: Plavix? _____ Coumadin? _____ Aspirin? _____ Anti-inflammatories: _____

PAST OR PRESENT MEDICAL CONDITIONS

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

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)	( ) HPV	( ) PPD	( ) Pneumonia
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: _____ History of military service? ( ) Yes ( ) No

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: _____

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*** any of the following symptoms you are having:

Allergic	**Endocrine**	**Integumentary (Skin)**
( ) Eye irritation ( ) Reactions ( ) Sneezing ( ) **NONE**	( ) Cold intolerance ( ) Hair loss / growth ( ) Heat intolerance ( ) Hot flashes ( ) **NONE**	( ) Bleeding ( ) Dry skin ( ) Itchy skin ( ) Lesions ( ) Rash ( ) **NONE**
Cardiovascular (Heart)	**Gastrointestinal (Stomach)**	**Musculoskeletal**
( ) Chest Pain ( ) Palpitations /fluttering of heart ( ) Shortness of breath while exercising ( ) **NONE**	( ) Constipation ( ) Diarrhea ( ) Pain ( ) Reflux (heartburn) ( ) Rectal Bleeding ( ) **NONE**	( ) Cramping ( ) Soreness ( ) Weakness ( ) **NONE**
Eyes / Ears / Nose / Throat	**Genitourinary**	**Neurological (Nerves)**
( ) Blurred vision ( ) Irritation from light ( ) Itching ( ) Nose blocked ( ) Painful eyes ( ) Post Nasal Drip ( ) Pressure in ears ( ) Rhinitis (runny nose) ( ) Sores in mouth ( ) Teeth hurt ( ) **NONE**	( ) Hesitation when urinating ( ) Pain when urinating ( ) Urination at night ( ) **NONE**	( ) Abnormal movements ( ) Dizziness / vertigo ( ) Fainting ( ) Ringing in the ears ( ) Twitch ( ) **NONE**
	Hematologic	**Psychiatric**
	( ) Bleeds easily ( ) Night sweats ( ) Weight loss ( ) **NONE**	( ) Anxiety ( ) Depression ( ) Loss of sleep ( ) Mood swings ( ) Situational Stress ( ) **NONE**
Respiratory (Lungs)		
( ) Cough ( ) Shortness of breath while sitting ( ) Wheezing ( ) **NONE**		

ADVANCED DIGESTIVE CARE, LLC
GASTROENTEROLOGY ASSOCIATES

PATIENT INFORMATION FORM

DATE: _____

NAME: _____ MALE_____ FEMALE _____

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: _____

CHECK ALL THAT APPLY: Single_____ Married_____ Widow(er) _____ Student_____

PREFERRED LANGUAGE: (circle one) English Spanish Other

RACE: (circle one) White/Caucasian African American Spanish/Hispanic Asian Other

ETHNICITY: (circle one) 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: _____SECONDARY: _____

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_____

ADVANCED DIGESTIVE CARE, LLC/ GASTROENTEROLOGY ASSOCIATES

Privacy Practices Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

* 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 acknowledge that I can ask for the full Notice of Privacy Practices of Gastroenterology Associates, P.C./Advanced Digestive Care, LLC 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 understand that I may request in writing that you restrict how my private health information is used or disclosed. I further understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

PATIENT CONSENT TO USE AND DISCLOSURE of

Protected Health Information for treatment, payment and healthcare operations

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 personal health information, 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 consent to treatment by GASTROENTEROLOGY ASSOCIATES, P.C./ADVANCED DIGESTIVE CARE, LLC, and to 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 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
_____	_____
_____	_____
_____	_____
_____	_____

ADVANCED DIGESTIVE CARE, LLC/GASTROENTEROLOGY ASSOCIATES

INSURANCE NOTICE AND AGREEMENT AND REFERRAL NOTICE

The practice of Gastroenterology Associates, P.C./Advanced Digestive Care, LLC, will file your insurance if we "*participate"* with your insurance plan. Any co-payment, deductible, etc. are to be paid in full at the time of each visit. We do not bill for co-payments. If our office does not participate with your insurance, it will be your responsibility to file your insurance claims directly with your company. You will be responsible for full payment at the time of service. Returned checks are charged a **$50.00** administrative fee. Accounts past due by 90 days will be charged a **$20.00** late fee. If payment is not received, the account will be turned over to our collection agency and/or attorney. This will be subject to a 25% charge to cover the collector's fees. We will be happy to discuss your proposed treatment and answer questions relating to your insurance.

1. I hereby authorize the release of any medical information and any filing of insurance claims pertaining to services rendered to myself by the practice of Gastroenterology Associates, P.C./Advanced Digestive Care, LLC.
2. I authorize and request Gastroenterology Associates, P.C./Advanced Digestive Care, LLC to charge my credit card for balances due for services rendered that my insurance company identifies as patient financial responsibility. There will be a $500.00 maximum for auto charge. If your patient responsibility is more than $500.00, we will follow up with you to discuss payment of the balance. This authorization relates to all payments not covered by my insurance company for services provided to me. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification in writing and the account must be in good standing.
3. I authorize payment of medical benefits to the practice of Gastroenterology Associates, P.C./Advanced Digestive Care, LLC, and understand the above policies and agree to financial responsibility for services not covered by my insurance. I further agree to accept any finance charges and/or collection fees assessed to my account for the untimely payment of overdue balances.
4. We require that you give our office a 24 business hour notice for office visit cancellations or you will be charged a **$50.00** cancellation fee. For patients having a procedure you will be required to give our office a 72 business hour notice if you are cancelling your procedure or you will be charged a **$200.00** cancellation fee.
5. It is your responsibility to know if your insurance company requires you to have a referral from your primary care physician. If a referral is required, you must obtain the referral. If referral is not obtained, patient will be responsible for payment.
6. If you are having a procedure, we cannot guarantee that your procedure will be covered or payable by your insurance company. Most insurance companies do not guarantee payment of a procedure until receipt of the claim from our office. Most insurers have clauses that state "based on medical necessity". As an example, a colonoscopy that your family/primary care doctor states is a "screening" may not be a payable diagnosis. It is your responsibility to speak with your insurance company if you have any questions concerning coverage for your procedure.

I, _____, understand that I will be responsible for payment of all charges incurred that my insurance company will not pay.

_____ _____

(Signature of patient or patient's representative) (Date)

PATIENT'S MEDICARE AUTHORIZATION: (MEDICARE PATIENTS ONLY)

The practice accepts assignment on all Medicare claims. However, any co-payment, deductible or non-covered service is your responsibility.

I request that payment of authorized Medicare benefits be made on my behalf to the practice of Gastroenterology Associates, P.C., Advanced Digestive Care, LLC, I authorize the practice of Gastroenterology Associates, P.C./Advanced Digestive Care, LLC to release to the Health Care Financing Administration, and its agents, that information needed to determine these benefits or the benefits payable for related services.

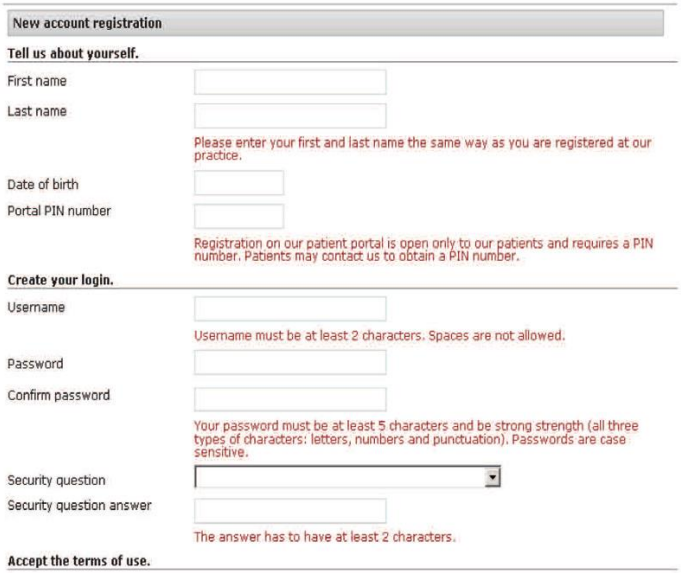
I understand my signature requests that payment be made, and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 on the HCFA-1500 form, or on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insured or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the payment determination of the Medicare carrier as the full payment and the patient is responsible only for their deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

(Signature of patient or patient's representative) (Date)

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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