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Welcome to our office,

Your initial visit is for an office consultation only. The medical necessity of any procedure such as upper endoscopy, colonoscopy, and/or any other diagnostic testing will be determined at the consultation. **There is NO Special preparation for this consultation**.

Please plan to arrive 15 minutes early for your first appointment.

Your appointment date is: _____; Arrival Time: _____

Please bring the following with you for your office consultation

- Attached patient information, **completed and signed prior to arrival**. If paperwork is not completed by your appointment time, your appointment may be rescheduled.
- Insurance card(s)
- Photo ID: Please note, if your address differs from what is printed on your driver's license or other photo ID, please bring a utility bill or other correspondence that shows your name and correct address.
- Insurance Referral Form; if applicably to your insurance policy.
- Medical Records for your consultation related to your medical condition and/or complaints.
- Current medication list and/or containers/bottles including any supplement(s) or herb(s).
- Your personal\work calendar so you may schedule a date/time for any testing and/or procedures your physician may order.

Please be prepared to pay your insurance co-pay, co-insurance, and\or deductible at your appointment. Our office collects the Medicare co-insurance at your appointment too. If you are unable to make payment, please contact our office to make arrangements otherwise your appointment may be rescheduled.

Certain insurance policies may require that a $150.00 deposit be collected on any procedure. The deposit is due prior to your procedure date. If you are unable to make payment, please contact our office to make arrangements.

Cancellations, missed, and rescheduled appointments and/or procedures

Appointment time has been reserved for you. We request that you contact our office to cancel or reschedule your appointment and/or endoscopy procedure a minimum of 2 business days in advance. This will give our office ample time to refill the open appointment with a patient who needs to be seen. Our office reserves the right to charge a $25.00 fee for multiple missed, rescheduled, or cancelled appointments. And Charge a $75.00 fee for failure to show up for an endoscopy procedure. **These fees are patient responsibility and are NOT billable to your insurance carrier.**

Multiple missed, rescheduled, and/or cancelled appointment or procedure may result in your discharge from our practice.

Patient Information

Name: (First, MI, Last)		Date of Birth:	
Address: (Street)		Social Security Number:	
Address: (City, State, Zip)		Age:	Sex:
Home Phone:	Cell Phone:		
Race:	Ethnicity:	Language:	
Marital Status:	Email Address:		
☐ Mailing Address Same as Patient Address			
Mailing Address: (Street)			
Mailing Address: (City, State, Zip)			
May we contact you at work? ☐ Yes ☐ No	Employer Name:		
Work Phone:	PCP/Referring Doctor:		
May we leave a detailed message on your answering machine? ☐ Yes ☐ No			
Emergency Contact:		Home Phone:	

Responsible Party/Guarantor Information

☐ Responsible Party Same as Patient		
Name: (First, MI, Last)		Date of Birth:
Address: (Street)		Social Security Number:
Address: (City, State, Zip)		Home Phone:
May we contact you at work? ☐ Yes ☐ No	Work Phone:	

Primary Insurance Information

☐ Self **or** Subscriber Name: (First, MI, Last)			
Address: (Street)			Date of Birth:
Address: (City, State, Zip)			Social Security Number:
Home Phone:	Sex:	Relationship to Patient:	
Insurance Company Name:		Policy ID:	
Group ID:		Effective Date:	
Employer Name:		Work Phone:	

Secondary Insurance Information

☐ Self **or** Subscriber Name: (First, MI, Last)			
Address: (Street)			Date of Birth:
Address: (City, State, Zip)			Social Security Number:
Home Phone:	Sex:	Relationship to Patient:	
Insurance Company Name:		Policy ID:	
Group ID:		Effective Date:	
Employer Name:		Work Phone:	

Tertiary Insurance Information

☐ Self **or** Subscriber Name: (First, MI, Last)			
Address: (Street)			Date of Birth:
Address: (City, State, Zip)			Social Security Number:
Home Phone:	Sex:	Relationship to Patient:	
Insurance Company Name:		Policy ID:	
Group ID:		Effective Date:	
Employer Name:		Work Phone:	

Confidentiality and Privacy under HIPPA

(Health Insurance Portability and Accountability Act of 1996)

☐ I acknowledge receipt of the Notice of Privacy Practices of Gastroenterology Associates.

☐ I acknowledge having already received the Notice of Privacy Practices of Gastroenterology Associates.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ Date of birth: _____

Please read carefully:

- All charges (e.g., co-pay, deductibles, self-pay, etc.) are due at the time professional services are rendered.
- For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Gastroenterology Associates.
- The patient is responsible for all fees. $150.00 deposit fee required on all procedures.
- The fee ticket may be used to file insurance claims.
- For minor: I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by Gastroenterology Associates.
- I hereby authorize Gastroenterology Associates to furnish information to any insurance company or authorized agency specified regarding information concerning my medical care.
- If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, court costs, and attorney fees, as allowed by law.
- Any check returned to us as unpaid will be charged a $50 fee.
- There may be a $25 charge for no show appointments.

_____ _____

Signature of Patient and/or Guardian (SEAL) DATE

Consent for Treatment:

I authorize providers at Gastroenterology Associates to perform examinations, procedures, laboratory tests and to administer such medications as, in his or her opinion, as necessary for my care.

Patient Signature: _____ Date: _____

Consent for Medication History:

☐ I consent to the use of my medication history from participating medical information exchanges.

☐ I have chosen to opt out of this program:

Patient Signature: _____ Date: _____

Release of Information:

Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize Gastroenterology Associates to release any information required in the course of my examination or treatment to the following designated persons:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____