Gastroenterology Associates

Pear M. Enam, MD, FACG • Rashid Hanif, MD, FACG • C.P. Choudari, MD, MRCP

Welcome to our office,

Your initial visit is for an office consultation only. The medical necessity of any procedures such as upper endoscopy, colonoscopy or other diagnostic test will be determined at the consultation. **There is no special preparation for this office visit.** Please arrive 15 minutes early for your first appointment.

Our office is located at:
11110 Medical Campus Road
Suite 250 (Silver Entrance)
Hagerstown, MD 21742
301-733-4404

Date Arrival Time

Please bring the following with you to 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 Cards and Photo ID (If your address differs from that which 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 necessary. (Many primary physicians' offices will not fax these forms)
- ✓ Medical records, if so instructed by your primary physician
- ✓ Current medication list or containers/bottles including any supplements or herbs.
- ✓ Your calendar, this will help you schedule a time for any testing / procedure the doctor may order.

Co-payments and Medicare Co-insurance are collected on the date of service prior to your office visit. Please be prepared to pay at this time. *If you are unable to make this payment, your appointment may be rescheduled. We require a $150 deposit on all procedures.*

Cancellations and rescheduled visits. Appointment times have been reserved for you. We request that you cancel or reschedule your office appointment or endoscopic procedure by phone a minimum of 2 business days in advance. This will give us ample time to fill those appointments with patients who need to be seen. There may be a charge of $25.00 for no show appointments and cancelled or rescheduled appointments without proper notice. Failure to show up for an endoscopic procedure may result in a charge of $75.00. This fee is not billable to your insurance company.

Multiple cancellations, reschedules or no show appointments may result in your discharge from our practice.

Please take a few minutes and visit our website at: www.gidoc.biz.

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: (Not living with you)		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: _____