GASTROENTEROLOGY ASSOCIATES

Phone (864) 232-7338

Thank you for choosing Gastroenterology Associates

As a new patient to our practice, we would like to welcome you and thank you for entrusting us with your care. In preparation for your upcoming appointment, PLEASE BRING THE FOLLOWING ITEMS:

- All of your medications OR a list of all of your medications (including dosage). List all over-the-counter medicine, vitamins, herbals, etc.
- Complete and bring all four (4) of the enclosed forms and questionnaires. Please do NOT mail.
- Insurance cards (and Medicare D drug card if it applies)
- Picture ID
- If your insurance requires pre-authorization for your visit, please bring the pre-authorization form provided by your primary care physician.

Please arrive 20 minutes prior to your scheduled appointment time.

If you need to cancel or reschedule please call our office at (864) 232-7338 at least 24 hours prior to your scheduled appointment to avoid a $25 late cancellation or missed appointment fee.

We look forward to providing your medical care.

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PATIENT INFORMATION SHEET

(Please complete all fields below)

Name: _____
(Last) (First) (Middle) (Nickname)

SS#: _____ Birth Date: _____ Sex: _____

Billing Address: _____
(Street or PO Box) (City) (State, Zip)

Secondary Address: _____
(If Different than Above) (Street or PO Box) (City) (State, Zip)

County: _____ Marital Status: _____ Preferred Language: _____

Race(check one): ☐White ☐Black or African American ☐ Hispanic ☐ American Indian or Alaska Native
☐Native Hawaiian or Other Pacific Islander ☐Asian ☐Other Race ☐Declined to specify

Ethnicity (check one): ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Specify

Primary Care Doctor:_____Referring Doctor:_____

Cell Phone: ( )_____ Home Phone: ( )_____ Email:_____
(please provide to receive an invite to our patient portal)

Appointment reminders by : ☐Phone Call
☐Email
☐Text (SMS)

Employer: _____

Emergency Contact: _____ _____ _____
(Name) (Relationship) (Phone #)

Primary Insurance Coverage

Name of Ins Co: _____ Member ID # _____

Name of Subscriber: _____ Subscriber SS #: _____ Subscriber DOB: _____

Subscriber Employer: _____ Relationship to Subscriber: _____

Secondary Insurance Coverage (if applicable)

Name of Ins Co: _____ Member ID # _____

Name of Subscriber: _____ Subscriber SS #: _____ Subscriber DOB: _____

Subscriber Employer: _____ Relationship to Subscriber: _____

Gastroenterology Associates uses Labcorp for laboratory services and Advanced Pathology Solutions for pathology (biopsy) services.
If your insurance requires a specific laboratory, please specify: Lab:_____ Pathology: _____

I consent to having my medical and demographic information shared with other health care entities. ☐Decline
I consent to obtaining a history of my medications purchased at pharmacies. ☐Decline
I consent to receive preventative and follow up care reminders. ☐Decline
I consent to being included in clinical reports. ☐Decline

I certify that the above information is true. I consent to the above statements, except for those I specified as declined, and I consent to any medical or surgical treatment rendered under the general and special instructions of the provider.

Signature of Patient/Guardian: _____ **Date:** _____

Authorization to Release Health Information

This form allows Gastroenterology Associates to communicate information about your care to you and those you list on this form. It will remain in effect until you end it in writing.

COMMUNICATING WITH YOU – DETAILED MESSAGES PERMITTED

Detailed messages may include the following information: (check all that apply)

☐ All information from this practice ☐ Billing/insurance information ☐ Appointment information only (request/confirm/cancel) ☐ Data breach notifications

Phone #: _____ ☐ Text (SMS)* ☐ Voicemail/answering machine

Other #: _____ ☐ Text (SMS)* ☐ Voicemail/answering machine

EMAIL* _____

*I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk. This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

This practice may communicate to the family members, friends, or caregivers listed below.

Name: _____ Name: _____

Phone: _____ Phone: _____

Email*: _____ Email*: _____

Relationship: _____ Relationship: _____

Check the box next to each type of information this practice may share with the individuals listed above.

☐ All Information ☐ Appointments ☐ Billing/Insurance ☐ Other _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- You do not have to sign this authorization to receive treatment from this practice.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits can be made on this form, initialed, and date instead of requiring a new form.
- This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.

X _____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Print Name Patient Date of Birth

(Attach documentation to support the personal representative's authority if not already on file with the practice)

Patient Financial Responsibility Statement

We ask that you please read and understand your financial responsibilities prior to receiving services.

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Financial Information

1. I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to Gastroenterology Associates, PA.
2. I understand that I am solely responsible for obtaining any necessary referrals and/or authorizations prior to my appointment.
3. I understand that if I do not have valid medical insurance, I am financially responsible for all fees at the time services are rendered.
4. I understand that I am expected to pay all copays, coinsurance, and deductibles at time of service.
5. I understand that I will be charged $30 for any check returned by my bank for any reason.
6. I understand it is my responsibility to inform Gastroenterology Associates if my insurance has changed.

No-Show & Late Cancellation Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Gastroenterology Associate's goal is to provide excellent and timely care to each patient. If it is necessary to cancel an appointment, patients are required to call or leave a message within the time frame stated below. Notifying our practice in a timely manner allows our providers to better utilize appointments for other patients in need of prompt medical care.

Procedures: Due to the amount of resources allocated for endoscopic procedures, we require at least 5 full business days' notice for cancellation or rescheduling of appointments. Patients will be assessed a fee of $250 for each documented no show or late cancellation for a procedure.

Office Appointments: To cancel or reschedule an office visit, please do so at least 24 hours prior to the scheduled appointment time. Patients will be assessed a fee of $25 for each documented no show or late cancellation.

In the event a patient has incurred three (3) documented "no-shows" and/or "late cancellations" within 1 year, the patient may be subject to dismissal from Gastroenterology Associates. Dismissals are determined by a physician after the patient's chart has been reviewed.

The charge for late cancellation/no-show of appointments will be billed directly to you and not to your insurance. We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case by case basis.

By signing below, I acknowledge that I understand and agree to these terms:

X _____ _____

Signature of Patient/Authorized Representative | Today's Date

_____ _____

Print Name | Patient Date of Birth

Name: | **DOB:** | **Reason for visit:**

GASTROENTEROLOGY ASSOCIATES

Have you had a screening colonoscopy? ☐ Yes ☐ No If yes, when?_____

Please check any persistent or recurring symptoms you have: ☐ **I'm having no symptoms**

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn/Reflux
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting

General:
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Weight loss
- ☐ Weight gain

Hematologic:
- ☐ Anemia
- ☐ Bleeding tendency

Neurological:
- ☐ Confusion
- ☐ Seizures
- ☐ Severe headache

Cardiovascular:
- ☐ Chest pain
- ☐ Irregular heart beats

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks

Skin:
- ☐ Itching
- ☐ Rash
- ☐ Breast lumps
- ☐ Jaundice/yellow skin

ENT:
- ☐ Cough
- ☐ Hard of hearing
- ☐ Hoarseness
- ☐ Vision Changes

Genitourinary:
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Trouble urinating

Musculoskeletal:
- ☐ Joint pain
- ☐ Muscle pain

Respiratory:
- ☐ Sleep apnea
- ☐ Shortness of breath

Social History:

Tattoos? ☐ Yes ☐ No | **Piercings?** ☐ Yes ☐ No | **Current Employer**: _____

Marital status: ☐ Single ☐ Married **Number of children**: _____

Tobacco Use: ☐ Never ☐ Former ☐ Current (every day) ☐ Current (some days) **Type:**_____

Alcohol Use: ☐ Never ☐ Former ☐ Current (every day) ☐ Current (some days) **Type:**_____

Caffeine: ☐ Never ☐ Former ☐ Current (every day) ☐ Current (some days) **Type:**_____

IV Drug Use: ☐ Never ☐ Former ☐ Current (every day) ☐ Current (some days)

Recent ER visit? ☐ Yes ☐ No **Date:**_____ | **Fallen in the last year?** ☐ Yes ☐ No **Date:**_____

Any of the following vaccinations? ☐ Hepatitis A ☐ Hepatitis B ☐ Influenza (Flu) ☐ COVID-19 ☐ Other _____

Surgical History: (Check all that apply)

- ☐ Colon Surgery
- ☐ Hemorrhoid Surgery
- ☐ Gallbladder Surgery
- ☐ Gastric Surgery
- ☐ Liver Surgery
- ☐ Hysterectomy
- ☐ Laparotomy
- ☐ Obesity Surgery
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Transplant Surgery
- ☐ Small Intestine Surgery
- ☐ Appendectomy
- ☐ Breast Surgery
- ☐ C-section
- ☐ CABG/Heart Surgery
- ☐ Hernia Surgery
- ☐ Prostate Surgery
- ☐ Spinal Surgery
- ☐ Tubal Ligation
- ☐ Valve Replacement Surgery
- ☐ Other _____

Medical History: (Check all that apply)

- ☐ High blood pressure
- ☐ Coronary Artery Disease
- ☐ Heart Stent
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Atrial Fibrillation (AFIB)
- ☐ COPD
- ☐ Diabetes
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Kidney disease
- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Colon Polyps
- ☐ Diverticulosis
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Hepatitis B
- ☐ Hepatitis C (HCV)
- ☐ Reflux
- ☐ Stomach Ulcers
- ☐ Cirrhosis
- ☐ Liver Disease
- ☐ Other: _____

Family History: (check all that apply and specify relationship)

	Relationship		Relationship
☐ Colon Cancer	_____	☐ Pancreas Cancer	_____
☐ Stomach Cancer	_____	☐ Prostate Cancer	_____
☐ Esophagus Cancer	_____	☐ Breast Cancer	_____
☐ Colon Polyps	_____	☐ Liver Disease	_____
☐ Crohn's Disease	_____	☐ Other _____	_____
☐ Ulcerative Colitis		☐ Other _____	

Allergies: (check all that apply)

- ☐ No known allergies
- ☐ Codeine Sulfate
- ☐ Versed
- ☐ Morphine
- ☐ Iodinated Contrast
- ☐ Fentanyl Citrate
- ☐ Propofol
- ☐ Penicillin
- ☐ Sulfa
- ☐ Demerol
- ☐ Latex
- ☐ Adhesive Tape
- ☐ Other _____
- ☐ Other _____

Medications: List current medications (including herbal and OTC) and dosage OR attach list

Name of drug	Strength/Frequency	Name of Drug	Strength/Frequency
1)		5)	
2)		6)	
3)		7)	
4)		8)	