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.

PATIENT INFORMATION SHEET

(Please complete all fields below)

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

SS#: Birth Date: Age 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:____________________________

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

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 Quest Diagnostics for laboratory services and Advanced Pathology Solutions for pathology (biopsy) services. If your insurance requires a specific laboratory, please specify: Lab:_________ Pathology: ______________

Gastroenterology Associates utilize generative AI transcription technology to generate medical notes and update a patient's medical chart in real-time. Natural language processing allows the transcription software to analyze and dictate human conversations as they occur, like a physician's scribe. Generative AI is an aid to the provider, but ultimately the provider will make a clinical decision using their own professional judgement.

Gastroenterology Associates utilizes technology to send preventative and follow up care reminders. Patient information may be used for financial and clinical reporting within the practice.

I certify that the above information is true 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. Signature is optional and not required to receive treatment and does not expire 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 can 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.
- 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 dated 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.
- This practice made the Notice of Privacy Practices available for my review and I understand my privacy rights.

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)

Cancellation and Financial Policy

GASTROENTEROLOGY ASSOCIATES

Canceling/Rescheduling Appointments and Procedures

Procedure Policy

- Cancellations less than **(7) days** before your procedure date will result in a **$100 fee**.
- **No-showing** procedure appointments will result in a **$250 fee**.
- Multiple rescheduled appts **(more than 2 times)** will result in a **$100 fee**. An office visit will also be required prior to rescheduling a 3rd time.

Office Visit Policy

- Cancellations less than **(24) hours** before, or **no-showing**, your office appointment date/time, will result in a **$25 fee**.

Our medical providers want to accommodate the needs of patients. This requires careful planning and coordinating among our office, providers, and other medical specialists such as Certified Registered Nurse Anesthetists (CRNAs). It is important to review your calendar to ensure appointment dates/times are ideal for you. We understand that sometimes it may be necessary to reschedule due to unforeseen circumstances. If you need to cancel or reschedule your appointment, we respectfully request appropriate notice so appointments can be offered to other patients in a timely manner. Chronic cancellations or no-shows may result in dismissal from our medical practice.

These cancellation and no-show fees will not be applied toward your office visit/procedure and will be added as a charge to your account that is not billed to insurance. If the procedure or office visit is canceled by our practice, there will be no fees charged to the patient.

Financial Obligations:

1. 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 am responsible for obtaining any necessary referrals and/or authorizations prior to my appointment.
3. If I do not have valid medical insurance, I am financially responsible for all fees at the time services are rendered.
4. I am expected to pay all copays, coinsurance, and deductibles at time of service.
5. I will be charged $30 for any check returned by my bank for any reason.
6. It is my responsibility to inform Gastroenterology Associates if my insurance has changed.

By signing below, I acknowledge that I understand the above cancellation guidelines and the following:

X ______________________________ ______________

Signature of Patient/Authorized Representative Today's Date

______________________________ ______________

Print Name Patient Date of Birth

Thank you for providing our office and our patients with this courtesy.

MRN #__________________*(office use only)*

Name:	DOB:	Reason for visit:

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)	