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 15 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 FORM

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: ☐ White ☐ Black or African American ☐ Other Race
☐ Asian ☐ American Indian or Alaska Native ☐ Declined to Specify
☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Cell Phone: ( )_____ Home Phone: ( )_____ Email: _____

Contact Preference: ☐ Text (SMS) ☐ Phone Call ☐ Email

Employer: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Care Provider: _____ **Referring Provider:** _____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Pharmacy Address: _____

Primary Insurance: _____ **Policy Number/ID:** _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Subscriber's Relationship to Patient: _____ **Insurance Phone Number:** _____

Secondary Insurance (if applicable): _____ **Policy Number/ID:** _____

Subscriber's Name: _____ **Subscriber's Date of Birth:** _____

Subscriber's Relationship to Patient: _____ **Insurance Phone Number:** _____

☐ **No Insurance**

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 utilize 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 treatment rendered under the general instructions of the provider.

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

Authorization to Release Health Information

Communications between Patients and their Families, Friends, or Caregivers

GASTROENTEROLOGY ASSOCIATES

This form allows **Gastroenterology Associates** to communicate information about your care to you and those you list on this form.

Patient Name: _____ **Date of Birth:** _____

Main Contact Number: _____ ☐ Home ☐ Cell* ☐ Work

COMMUNICATING WITH YOU

Detailed messages regarding results or protected health information are permitted by: ***(check all that apply)***

☐ Text (SMS)* ☐ Main Contact Number Above ☐ Voicemail ☐ None

☐ Other Contact Number: _____

* 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

Gastroenterology Associates may communicate with the individuals listed below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Check the box to each type of information we **CAN** share with the individuals listed above:

☐ All information ☐ Prescriptions ☐ Appointments ☐ Billing/Insurance

☐ Other: _____

Do not include:

☐ Mental health records ☐ Alcohol/drug treatment ☐ Communicable diseases

PATIENT RIGHTS & SIGNATURE

- This Authorization will remain in effect until the patient completes and submits a new Authorization form that supersedes this one. The patient may revoke or modify this Authorization at any time, provided that the revocation or modification is in writing and delivered to our practice. See our Notice of Privacy Practices for exceptions. A termination will not apply to any release of information that happens before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- 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.
- The Notice of Privacy Practices was made available for my review, and I understand my privacy rights.

_____ _____

Patient/Personal Representative Signature **Date**

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney): _____

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

Cancellation and Financial Policy

Patient Name: _____ **DOB:** _____

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 coordination 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

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

MRN #_____*(office use only)*

Gastroenterology Associates
(864) 232-7338
www.gastroassociates.com

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

MRN: _____ Date Of Birth: _____

Age: _____ Notes: _____

Email

Personal: _____

Pharmacy

Name	Address	Phone

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

☐ Yes ☐ No

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

☐ Yes ☐ No

Current Medications

☐ None

Name	Dose	How taken?

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

- [ ] Latex
- [ ] morphine
- [ ] Demerol
- [ ] Codine Sulfate
- [ ] Fentanyl Citrate in NS (PF)
- [ ] Versed
- [ ] Adhesive Tape
- [ ] Penicillins
- [ ] Iv Dye, Iodine Containing Contrast Media
- [ ] Sulfa(Sulfonamide Antibiotics)
- [ ] Propofol

Other: _____

Immunizations

- [ ] None

- [ ] Hep A, adult When: _____
- [ ] Hep B When: _____
- [ ] Flu vaccine When: _____
- [ ] COVID-19 When: _____

Other: _____

Review Of Systems

Gastrointestinal

- [ ] None

	Y	N
abdominal pain	○	○
constipation	○	○
diarrhea	○	○
heartburn	○	○
nausea	○	○
rectal bleeding	○	○
vomiting	○	○
difficulty swallowing	○	○
Hx of Screening Colo	○	○

Constitutional

- [ ] None

	Y	N
fatigue	○	○
fever	○	○
weight gain	○	○
weight loss	○	○

Hematologic/Lymphatic

- [ ] None

	Y	N
anemia	○	○
bleeding tendency	○	○

Neurological

- [ ] None

	Y	N
dizziness	○	○
frequent headaches	○	○
seizures	○	○
confusion	○	○
Falls in the last year	○	○

Cardiovascular

- [ ] None

	Y	N
chest pain	○	○
irregular heart beat	○	○

Integumentary

- [ ] None

	Y	N
itching	○	○
jaundice	○	○
rashes	○	○
Tattoos	○	○
Piercings	○	○

Endocrine

- [ ] None

	Y	N
heat intolerance	○	○
cold Intolerance	○	○

ENMT

- [ ] None

	Y	N
hearing loss	○	○
cough	○	○
hoarseness	○	○
vision changes	○	○

Genitourinary

- [ ] None

	Y	N
frequent urination	○	○
painful urination	○	○
trouble urinating	○	○

Musculoskeletal

- [ ] None

	Y	N
joint pain	○	○
muscle pain	○	○

Respiratory

- [ ] None

	Y	N
shortness of breath with exercise	○	○
sleep apnea	○	○

Diagnostic Studies/Tests

- [ ] None

Imaging

- ☐ CT Abdomen/Pelvis — When: _____
- ☐ Abdominal Ultrasound — When: _____
- ☐ RUQ Ultrasound — When: _____
- ☐ MRI Abdomen/Pelvis — When: _____
- ☐ MRI Liver with and with contrast — When: _____

GI:

- ☐ Barium Swallow — When: _____
- ☐ EGD — When: _____
- ☐ Colonoscopy — When: _____
- ☐ ERCP — When: _____
- ☐ PEG tube placement — When: _____
- ☐ Capsule Endoscopy — When: _____
- ☐ EUS — When: _____

Miscellaneous:

- ☐ Labs — When: _____
- ☐ X-Rays — When: _____
- Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Civil Union
- ☐ Unknown
- ☐ Other

Tobacco

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Unknown if ever smoked

Alcohol

☐ None

Type	Quantity	Number	Frequency
☐ Alcohol			

Caffeine

☐ None

☐ Daily ☐ Occasionally

Drug Use

☐ None

Type	Quantity	Number	Frequency
☐ Recreational			
☐ Inhalants			
☐ Depressants			
☐ Hallucinogens			
☐ Steroids			
☐ Stimulants			
☐ IV or intranasal drugs			

Previous Procedures

☐ None

- ☐ Colon Surgery When:_____
- ☐ Pacemaker When:_____
- ☐ Hernia Surgery When:_____
- ☐ Liver Surgery When:_____
- ☐ Obesity Surgery When:_____
- ☐ Appendectomy When:_____
- ☐ Prostate Surgery When:_____
- ☐ Tonsillectomy When:_____
- ☐ Thyroidectomy When:_____
- ☐ C-Section When:_____
- ☐ Breast Surgery When:_____
- ☐ Spinal Surgery When:_____
- ☐ Tubal ligation When:_____
- ☐ Gastric Surgery When:_____
- ☐ Exploratory Laparotomy When:_____
- ☐ Hysterectomy - Abdominal When:_____
- ☐ Hemorrhoid banding When:_____
- ☐ Transplant Surgery When:_____
- ☐ Small Intestine Surgery When:_____
- ☐ Gallbladder Surgery When:_____
- ☐ Defibrillator Placement When:_____
- ☐ Hemorrhoid Surgery When:_____
- ☐ Coronary Artery Bypass Graft (CABG) When:_____
- ☐ Valve Replacement Surgery When:_____
- Other:_____

Past or Present Medical Conditions

- ☐ None

- ☐ Personal history of other colon polyps
- ☐ Adenomatous colon polyp
- ☐ High blood pressure
- ☐ Coronary Artery Disease
- ☐ Atrial Fibrillation
- ☐ Kidney disease
- ☐ Ulcerative Colitis
- ☐ Stomach Ulcers
- ☐ Blood Transfusion
- ☐ Crohn's Disease
- ☐ Cirrhosis
- ☐ Heart Stent
- ☐ Diabetes
- ☐ Anemia
- ☐ Hepatitis B
- ☐ Liver disease
- ☐ Seizures
- ☐ Hepatitis C
- ☐ Sleep apnea
- ☐ Diverticulosis
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ GERD (gastroesophageal reflux disease)
- ☐ Personal history of hyperplastic colon polyps
- Other:_____

Family Medical History

- ☐ No knowledge of family history

No family history of

- ☐ Celiac sprue
- ☐ Colon polyps
- ☐ Liver disease
- ☐ Ulcerative Colitis / IBD
- ☐ Colon cancer
- ☐ Crohn's disease
- ☐ Stomach cancer

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Health Status						
Healthy	○	○	○	○	○	○
Deceased/At Age	○____	○____	○____	○____	○____	○____
Cause of Death						
Diagnoses						
Personal History of colon cancer	○	○	○	○	○	○
Personal history of colon polyps	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Esophageal cancer	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○

Prostate cancer	○	○	○	○	○	○
Breast cancer	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Reviewed with

⬭ Patient ⬭ Parent ⬭ Guardian ⬭ Not Present