Patient Payment Policy for Gastroenterology Consultants, P.C.

Dear Patient,

Your insurance company may pay all, a portion, or none of your bill for services performed by our providers. Because of this you are asked to assume responsibility for any uncovered balance on your account. Payment guidelines for office charges are as follows:

All Patients

- Insurance Card: We will ask for your insurance card at check in and scan it into our system.
- Photo ID: We may ask to see and scan a government issued photo ID upon check in to verify your identity.

Insured Patients

- As a courtesy to our patients, we bill all insurance plans a maximum of two times.
- Your copay or deductible is due at the time of service.
- If you are unable to pay your deductible "in full" at the time of service, you will be required to meet with a member of our Billing Department to set up an appropriate payment plan.
- Payment plans will not be accepted for copays; they are due and payable at the time of service per your contract with your insurance company.
- Payment in full is due at the time of service for patients who do not provide a copy of their insurance card.
- IMPORTANT: Our office will code your visit/procedure based on the information given by you to the provider at your visit; on the information entered by you on your history form and on what is found (if anything) during your procedure. We cannot change codes to ensure payment by your insurance company. This is considered fraud.

Uninsured Patients

- New patient and consultation fees are $80 - $475 for office visits. A payment of $225 will be collected upon check in. (There is no charge for Group Education Classes)
- If the provider determines you need a diagnostic procedure (colonoscopy, endoscopy, etc.) you will be required to meet with a member of our Billing Department prior to scheduling. Full payment of the estimated cost of the procedure is required before the procedure is scheduled.

Checks Returned for Insufficient Funds

- There will be a $25 fee for checks returned to us from the bank for non-payment or insufficient funds.

Appointment Cancels or No Shows

- **Please remember that it is your responsibility to keep your appointment time.**
- **As a courtesy, our automated system will call 2 days prior to office appointments to confirm the time and date. However, if you do not show up for your scheduled appointment because you did not receive the courtesy confirmation call, it will be treated as a No Show and a charge may be applied to your account.**
- If you are unable to keep your office appointment with us, please call at least 2 business days prior to your appointment date. This courtesy enables us to offer your original time to another patient that needs to be seen.
- If you are unable to keep your procedure appointment with us, please call us at least 5 business days prior to your appointment date.

For No Shows or Short Cancellation Notice, penalties are as follows:

- **$25 for no-show or short cancellation for a return office appointments**
- **$50 for no-show or short cancellation a new patient appointments**
- **$100 for no-show or short cancellation for all procedure appointments**

PATIENT COPY ONLY

Dismissal Policy

- Gastroenterology Consultants, P.C. expects and requires cooperation from our patients. This cooperation is needed for adequate and safe health care. If a patient does not cooperate with the provider and/or staff of GCPC, another health care practice may better serve the patient.

A patient may be dismissed from GCPC if:

- The general behavior in the clinic is disruptive. This includes abusive verbal language or threats towards the providers or office staff.
- The patient forges prescriptions or obtains prescriptions under false pretenses.
- Severe patient non-compliance that jeopardizes his/her health significantly, despite recurrent attempts to correct the problem by the provider and/or office staff.

- **GCPC policy is after 2 no-show / late cancellations, patient may be dismissed from the practice.**
- **Generally, a patient will be notified before being dismissed. However, in the case of physical abuse, violation of a provider-patient medication contract, or forgery, the dismissal may occur without warning.**

Billing Policy

- Account balances are to be paid in full within 30 days of receiving your statement.
- If your account falls into delinquent status, or you default on a prearranged payment plan, your account will be sent to collections. Any extra fees associated with this process will be added to the balance and turned in for collection.
- Any billing disputes must be submitted in writing within 30 days of receipt of statement.

Other Healthcare Providers and Services:

- Certain services we provide will generate bills from other healthcare providers, such as radiology, facilities, pathology, and/or reference laboratories. These bills are separate from our office and are your responsibility.

Hospital and Surgical Benefits Authorization

I hereby assign all hospital, medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance, primary or secondary, and any other health plan to Gastroenterology Consultants, P.C. for services provided by Gastroenterology Consultants, P.C.

I request that payment under the medical insurance program be made either to me or the provider named above on any bills for services furnished to me during the effective period of this authorization, and I authorize the above-named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

PATIENT COPY ONLY

YOUR ELECTRONIC SIGNATURE WILL BE OBTAINED IN OUR OFFICE acknowledging: Payment policy, HIPAA, & Medication Consent.

OFFICE COPY - USE BLACK INK & RETURN ASAP PLEASE

Patient Name **Date of Birth** **SS#** _____

Marital Status: □ Married □ Single □ Widowed □ Divorced

Race of Patient: □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian □ Other Race □ Other/Multi □ White ***Ethnicity of Patient:*** □ Hispanic or Latino □ Not Hispanic or Latino

Email address:_____ (allows patient portal access).

Home Phone _____Cell Phone _____ Work Phone_____

Emergency Contact (not living with you) _____ Phone_____

Our goal is to provide you with the best medical care, if you require assistance due to: Hearing, Visual, or other impairment, please advise our staff accordingly.

_____

Primary Language (please specify language) _____

Patient Employment Status: □ Employed □ Unemployed □ Retired □ Self-Employed □ Student □ Disabled

Employer_____

Spouse's Name (Last)_____ (First)_____ Date of Birth Spouse)_____

Primary Insurance Coverage _____Insured through employer? □ Yes □ No

Name of Policy Holder _____Date of Birth_____
ID#_____ Group#_____

Relationship to Insured: □ Self □ Spouse □ Child □ Other

Secondary Insurance Coverage _____ Insured through employer? □ Yes □ No

Name of Policy Holder _____Date of Birth_____
ID#_____ Group#_____
Relationship to Insured: □ Self □ Spouse □ Child □ Other

Preferred Pharmacy and location_____

PLEASE SEND COPIES OF INSURANCE CARDS, FRONT & BACK.

OFFICE COPY - USE BLACK INK & RETURN ASAP PLEASE

Patient Security Questions

Please fill out **at least two** of the following security questions. This will give us an additional tool to protect you from identity theft. We will use these questions and answers when you call into our office to make changes (address, phone number and insurance) to your account with us. We appreciate your cooperation.

Your First Car: _____

Best Friend in High School: _____

Favorite Team: _____

Medication History Consent

During your appointment with your provider we are able to access medication history from your pharmacy. Please review consent options so that we can have the most accurate medication list available to your provider.

PATIENT CONSENT **(SELECT ONE)**

☐ No Consent

☐ Consent given

☐ Prescriber – Patient gave consent for prescriber to only receive the medication history this prescriber prescribed.

☐ Parental/Guardian consent on behalf of a minor for prescriber to receive the medication history from any prescribe.

☐ Parental/Guardian consent on behalf of a minor for prescriber to only receive the medication history this prescriber prescribed.

HIPAA CONSENT

1. May we leave detailed medical information on your answering machine / voicemail? ☐ **Yes** ☐ **No**

2. Our office uses an auto dialer program to confirm appointments. **If you wish to opt out, mark here ☐. If you choose to opt out, please be aware of our office no show policy as there may be fees incurred.**

3. In addition to the above agreement, may we disclose your **health information** to a family member or friend**?** ☐ **Yes** ☐ **No**

4. If you answered YES to question 3, please print family/friends names here:

Gastroenterology Consultants, P.C .

Date:

Patient Name:Patient Name **Date of Birth: Date of Birth** **Acct# Code**

Referring Physician: Primary Care Provider:

May we send a report to your physician? Yes ☐ No ☐

What is your chief complaint for today's visit?

Are you allergic to any medication: Yes ☐ No ☐ If yes, please list the medication **AND** reaction:

Have you had the Influenza Vaccine Yes ☐ No ☐ **Pneumonia Vaccine** Yes ☐ No ☐

Has anyone in your Immediate Family had any of the following? ☐ None

	Who/Age?		Who/Age?
☐	Chronic Acid Reflux	☐	Liver Disease
☐	Colitis	☐	Pancreatic Cancer
☐	Colon Cancer	☐	Pancreatic Disease
☐	Colon Polyps	☐	Stomach Cancer
☐	Crohn's Disease	☐	Ulcer Disease
☐	Gallstones	☐	Other Cancer (type)?

Please list any past procedures and/or radiology tests you have had. ☐ None

	Date/Where:		Date/Where:
☐	Barium Enema	☐	Small Bowel Series
☐	Colonoscopy	☐	Ultrasound
☐	CT Scan	☐	Upper Endoscopy
☐	Liver Biopsy	☐	Upper GI Series
☐	Sigmoidoscopy	☐	Others, please list:

Please list any previous surgeries you have had. ☐ None

	Date/Where:		Date/Where:
☐	Appendix	☐	Hysterectomy Vaginal or Abdominal
☐	Colon	☐	Small Bowel
☐	Esophagus	☐	Cesarean
☐	Gallbladder	☐	Others, please list:
☐	Heart	☐	Others, please list:

Personal Habits

Alcohol	Yes ☐	No ☐	# per day?	**Tobacco** ☐	**Current:** ☐ Cigarettes or ☐ Chew
Coffee	Yes ☐	No ☐	# per day?		# per day?
Cola/Soda	Yes ☐	No ☐	# per day?	☐	**Former**: year/age quit? ☐ **Never**
Illegal Drug Use	Yes ☐	No ☐	Type:	**Medical Marijuana Card**	Yes ☐ No ☐

FOR OFFICE USE ONLY:

☐HIPAA ☐ID ☐ Ins ☐ Gen. Cons. ☐Sec. Ques. ☐ RX Cons. Provider_____Date_____

Have you ever had any of the following? ☐ CONDITIONS BELOW DO NOT APPLY

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Hepatitis
- ☐ Blood Transfusion (year)? _____
- ☐ CAD (Coronary Artery Disease)
- ☐ Cancer (type)? _____
- ☐ CHF (Heart Failure)
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes I ☐ II ☐
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ Esophageal Stricture
- ☐ Fatty Liver
- ☐ Fecal Incontinence
- ☐ GERD (Acid Reflux)
- ☐ Hepatitis, B ☐ or C ☐
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Migraine Headaches
- ☐ MRSA (Drug Resistant Staph)
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Pancreatic Disease
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Psychiatric Disorders
- ☐ Sleep Apnea with C-pap (level)? ____
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Other Conditions: _____ _____

IT IS IMPORTANT FOR YOUR PROVIDER TO KNOW WHAT MEDICATIONS YOU ARE TAKING. PLEASE BRING A COMPLETE LIST WITH CORRECT SPELLING/DOSAGE/AND DIRECTIONS TO YOUR APPT.

Current Medications	Dose (mg, ml, mcg)	Directions

Please check all that currently apply: ☐ SYMPTOMS BELOW DO NOT APPLY

CARDIOVASCULAR
- ☐ Ankle Swelling
- ☐ Chest Pain
- ☐ Palpitation

CONSTITUTIONAL
- ☐ Chills
- ☐ Fevers
- ☐ Weight Loss/Gain

EYES, EARS, MOUTH
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Vision Loss
- ☐ Yellow Eyes

RESPIRATORY
- ☐ Cough
- ☐ Hoarseness
- ☐ Productive Cough
- ☐ Wheezing

GENITOURINARY
- ☐ Blood in Urine
- ☐ Burning on Urination
- ☐ Frequent Urination

HEMATOLOGIC
- ☐ Easily Bleeds
- ☐ Swollen Glands

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Muscle Pain

NEUROLOGIC
- ☐ Fainting Spells
- ☐ Headaches
- ☐ Seizures

SKIN
- ☐ Itching
- ☐ Jaundice (Yellow Skin)
- ☐ Rashes

For Office Use Only

Height:	**Weight:**
BP:	**Pulse:**
Initials:	**Date:**
MA Group ☐	**DAC** ☐

Patient Name: **Date of Birth:**

Patient Name
Contact Address
CSZ