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In order to expedite scheduling your Direct Access.

You will find included with this letter a package of demographic and medical history paperwork. Please fill the paperwork out completely, include a copy of the front and back of current insurance cards and return to our office in the envelope provided. Once the completed paperwork AND insurance information is received and reviewed, you will be contacted to schedule the appropriate appointment.

Due to heavy patient care in the office, calls for scheduling will be made as quickly as possible.

If your insurance is a managed care plan (Allcare Advantage, some Oregon Health Plans, VA/Triwest, Providence Choice or Providence Connect) contact your primary care physician prior to making this appointment. Your Insurance requires an authorization to be in place before you can be seen in our office. This must be requested by your Primary Care doctor.

If it is being recommended that you should come back sooner than ten years due to a Person or Family history of Colon Cancer or Colon Polyps, please check with your Insurance as to their coverage guidelines.

Our office must receive your completed paperwork and copies of insurance card / photo ID. We will schedule your appointment only when these are received along with your completed paperwork.

Thank you,

Scheduling Staff



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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 must receive copies of your cards (front and back) along with your paperwork for billing to route correctly.
- Photo ID: a copy of your photo ID is needed as well.

Insured Patients

- As a courtesy to our patients, we bill all insurance plans a maximum of two times.
- Payment in full is due 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 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

- There is no charge for Group Education Classes
- You will be contacted by, 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, the facility will call you prior to your appointment 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 may be treated as a No Show and a charge may be applied to your account.
- If you are unable to keep your procedure appointment with us, please call us at least 5 business days prior to your appointment date.

Please return this form to our office

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

- **\$100 for no-show or short cancellation for all procedure appointments**

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 patient's general behavior in the clinic is disruptive, uses abusive verbal language, or is threatening towards 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 that after 3 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 may be sent to collections. Any extra fees associated with this process will be added to the balance 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 have read and understand the above Payment Policy, which includes assignment of benefits.

Name (Print)

Signature of Patient

Date

Medicare Authorization

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.

Signature _____

Authorization Period: Today's date _____ (valid for 4 years)

How did you hear about us? Internet Radio Other; _____

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: _____ (For patient portal access). Primary Language (specify) _____

Primary Phone _____ Secondary Phone _____ Work Phone _____

Emergency Contact _____ Phone _____

If you require assistance due to: Hearing, Visual, or other impairment, please advise our staff accordingly.

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 _____

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: _____

City you were born: _____

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 prescriber.

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

HIPPA CONSENT

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

2. In addition to the above agreement, may we disclose your **health information** to your spouse, family members or friends?

Yes **No**

3. If you answered **YES** to question 2, please print, **first and last name**, of your spouse and/or family members/friends

here: _____



Gastroenterology Consultants, P.C.

Date: _____

Patient Name: _____ Date Of Birth: _____

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 Date: _____
Pneumonia Vaccine Yes No Date: _____

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

- | <u>Who/Age?</u> | <u>Who/Age?</u> |
|--|---|
| <input type="checkbox"/> Chronic Acid Reflux | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pancreatic Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Pancreatic Disease |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Stomach Cancer |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Ulcer Disease |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Other Cancer (type)? |

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

- | <u>Date/Where:</u> | <u>Date/Where:</u> |
|--|---|
| <input type="checkbox"/> Barium Enema | <input type="checkbox"/> Small Bowel Series |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Upper Endoscopy |
| <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Upper GI Series |
| <input type="checkbox"/> Sigmoidoscopy | <input type="checkbox"/> Others, please list: |

Please list any previous surgeries you have had. None

- | <u>Date/Where:</u> | <u>Date/Where:</u> |
|--------------------------------------|---|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Hysterectomy
Vaginal or Abdominal |
| <input type="checkbox"/> Colon | <input type="checkbox"/> Small Bowel |
| <input type="checkbox"/> Esophagus | <input type="checkbox"/> Cesarean |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Others, please list: |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Others, please list: |

Personal Habits

Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	# per day?	Tobacco	<input type="checkbox"/> Current	<input type="checkbox"/> Cigarettes or	<input type="checkbox"/> Chew
Coffee	Yes <input type="checkbox"/>	No <input type="checkbox"/>	# per day?	# per day	Former: year/age quit		<input type="checkbox"/> Never
Cola/Soda	Yes <input type="checkbox"/>	No <input type="checkbox"/>	# per day?	Medical Marijuana Card	<input type="checkbox"/> Yes		<input type="checkbox"/> No

Illegal Drug Use Yes No Type:

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

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

IT IS IMPORTANT FOR YOUR PROVIDER TO KNOW WHAT MEDICATIONS YOU ARE TAKING. PLEASE PROVIDE A COMPLETE LIST WITH CORRECT SPELLING/DOSAGE/AND DIRECTIONS OR USE THE SPACE BELOW.

Current Medications	Dose (mg, ml, mcg)	Directions

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

- | | |
|---|---|
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Burning on Urination |
| <input type="checkbox"/> Palpitation | <input type="checkbox"/> Frequent Urination |
| <u>CARDIOVASCULAR</u> | <u>HEMATOLOGIC</u> |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Easily Bleeds |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Weight Loss <input type="checkbox"/> weight Gain | <u>MUSCULOSKELETAL</u> |
| <u>EYES, EARS, MOUTH</u> | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Mouth Sores | <u>NEUROLOGIC</u> |
| <input type="checkbox"/> Vision Loss | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Yellow Eyes | <input type="checkbox"/> Headaches |
| <u>RESPIRATORY</u> | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cough | <u>SKIN</u> |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Productive Cough | <input type="checkbox"/> Jaundice (Yellow Skin) |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Rashes |