Gastroenterology Consultants, PC

Patient Name
Contact Address
CSZ

Report Date

Dear Patient Name,

In order to expedite scheduling your Direct Access for Choose an item

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,

Login Name

Acct # Code

Gastroenterology Consultants PC P ♦ (541) 779-8367 F ♦ (541) 779-7471
2860 Creekside Circle ♦ Medford OR 97504
gcpcmedford.com

Gastroenterology Consultants, P.C .

Patient Name
Contact Address
CSZ

DAC/DAE/User Name

Office & Payment Policy for Gastroenterology Consultants, P.C. patients:

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.
- Any audio or video recordings are strictly prohibited unless approved by the provider prior to the visit.

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 at your visit; or, 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.

_____ _____ _____

Print Name **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.

_____ _____

Print Name **Signature of Patient**

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

Patient Security Questions

Please fill out the following security question. This will give us an additional tool to protect you from identity theft. We will use this question and answer when you call into our office to make changes (address, phone number and insurance) to your account with us. We appreciate your cooperation.

City you were born: _____

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.

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: _____

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

Employer: _____ SS#_____

Phone number: _____ Cell number: _____

Local Pharmacy: _____

DAE/DAC: Provider Name

Gastroenterology Consultants, P.C . **Date:** Report Date

Patient Name 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 ☐ **Date:** _____
Pneumonia Vaccine Yes ☐ No ☐ **Date:** _____

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 Former: year/age quit	☐ Never
Cola/Soda	Yes ☐	No ☐	# per day?	Medical Marijuana Card ☐ Yes	☐ No
Illegal Drug Use	Yes ☐	No ☐	Type:		

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 ☐ C ☐
- ☐ High Blood Pressure
- ☐ Pulmonary Hypertension
- ☐ High Cholesterol
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Aortic Stenosis
- ☐ 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 PROVIDE A COMPLETE LIST WITH CORRECT SPELLING/DOSAGE/AND DIRECTIONS OR USE THE SPACE BELOW.

Current Medications	Dose (mg, ml, mcg)	Directions

Patient Name **Date of Birth**