Gastroenterology Consultants, PC

Dear Patient,

In order to expedite the scheduling your Direct Access for either your Colonoscopy or Endoscopy, we ask that you review this packet information.

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,

Gastroenterology Consultants, PC

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

Gastroenterology Consultants, P.C .

Patient Name _____ D .O.B. _____

DAC/DAE

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 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 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.

HIPAA 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

Patient Current mailing address: _____

City/State: _____ Zip: _____

Preferred number: _____ Cell: yes or no _____

Employer: _____ SS #:_____

Local Pharmacy & Location: _____

Emergency Contact Name: _____ Phone: _____

INSURANCE INFORMATION: Please include copies of cards front & back in order to schedule

Primary Insurance Plan Name: _____ Insurance ID # _____ Group #_____

Subscriber Info: Please circle one: **Self Spouse Parent Other (Specify): _____**

Subscriber Name & Date of Birth (if not self): _____

Secondary Insurance Plan Name: _____ Insurance ID #_____Group #_____

Subscriber Info: Please circle one: **Self Spouse Parent Other (Specify): _____**

Subscriber Name & Date of Birth (if not self): _____

Patient Name **Date of Birth**

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 ☐

Reason for visit: screening colonoscopy

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:** _____
COVID 19 Vaccine Yes ☐ No ☐ **Date:** _____ **Booster: Y/N** _____

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?
Coffee Yes ☐ No ☐ # per day?
Cola/Soda Yes ☐ No ☐ # per day?
Illegal Drug Use Yes ☐ No ☐ Type:

Tobacco Yes ☐ No ☐
Cigarettes ☐ Chew ☐ # per day?
Former: year/age quit Never ☐
Vape: Yes ☐ No ☐
Marijuana Yes ☐ No ☐

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/Supplements	Dose (mg, ml, mcg)	Directions

Patient Name **Date of Birth**

Oregon Department of Human Services

Race, Ethnicity, Language, and Disability (READ)

Oregon Health Authority

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Please contact _____ at _____

Today's Date: _____ Medical record number (*if applicable*): _____

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

   _____

2. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black and African American
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories
- ☐ Other *(please list)*
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?
   - ☐ Yes. Please circle your primary racial or ethnic identity above.
   - ☐ I do not have just one primary racial or ethnic identity.
   - ☐ No. I identify as Biracial or Multiracial.
   - ☐ N/A. I only checked one category above.
   - ☐ Don't know
   - ☐ Don't want to answer

(To be filled in by agency or clinic staff)

Agency or clinic: **Agency staff or provider name or ID:**

Phone: **Address:**

Continued on next page

Language (*Interpreters are available at no charge*)

4a. What language or languages do you **use at home**? _____

Skip to question 7 if you indicated English only

4b. In what language do you want us to communicate in **person, on the phone, or virtually** with you?

_____

4c. In what language do you want us to **write** to you? _____

5a. Do you need or want an **interpreter** for us to communicate with you?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

☐ Spoken language interpreter
☐ American Sign Language interpreter
☐ Other ***(please list)***: _____
☐ Deaf Interpreter for DeafBlind, additional barriers, or both
☐ Contact sign language (PSE) interpreter

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Don't know ☐ Don't want to answer

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.*)		Yes	***If yes**, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking
7.	Are you **deaf** or do you have **serious difficulty hearing**?	☐		☐	☐	☐	
8.	Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?	☐		☐	☐	☐	
	Please stop now if you/the person is under age 5						
9.	Do you have **serious difficulty walking or climbing stairs**?	☐		☐	☐	☐	
10.	Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?	☐		☐	☐	☐	
11.	Do you have **difficulty dressing or bathing**?	☐		☐	☐	☐	
12.	Do you have **serious difficulty learning how to do things most people your age can learn**?	☐		☐	☐	☐	
13.	Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?	☐		☐	☐	☐	
	Please stop now if you/the person is under age 15						
14.	Because of a **physical, mental or emotional condition**, do you have **difficulty doing errands alone** such as visiting a doctor's office or shopping?	☐		☐	☐	☐	
15.	Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?	☐		☐	☐	☐	

Name: _____ DOB_____ Date_____

	Yes	No
Constipation	☐	☐
Diabetic ☐ Type I ☐ Type II	☐	☐
Joint Replacement less than 3 months	☐	☐
Mechanical Heart Valve	☐	☐
Latex Allergy	☐	☐
MRSA	☐	☐
Bipap or Cpap greater than level 12	☐	☐
Seizure Disorder	☐	☐
COPD	☐	☐
Implantable Defibrillator	☐	☐
Recent Heart Attack, Stroke or Cardiac stent placed	☐	☐
Multiple Cervical Fusions	☐	☐
24 Hr Supplemental Oxygen	☐	☐
Dialysis	☐	☐
☐ Pulmonary HTN ☐ Aortic Stenosis	☐	☐
Are you out of breath after climbing stairs	☐	☐
Pending/Upcoming Heart Test	☐	☐
Are you taking a Blood Thinner	☐	☐
Tested positive for Covid within 90 days	☐	☐