Gastroenterology Specialists of Dekalb, LLC

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential. Also, please provide the receptionist a picture id and your insurance card

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Patient's Social Security #
Address City State		Zip	Home Phone:
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate if not self ____/____/_____	Responsible Party's Social Security (if different)#
Name of employer Address		Business Phone	How long at current Employer?
Email:		Occupation	
Responsible Party Drivers License State: Number:			Marital Status Single **[ ]** Married **[ ]** Widowed [ ] Divorced [ ]

Name of Spouse/Parent	Spouse Birthdate	Spouse Social security #	Spouse Business phone
Referring Physician and Phone Number:		Pharmacy Name Address & Phone Number	
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicare Yes ✓ ✓ No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Primary insurance company Address				Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #		Group #
Secondary insurance name Address			Policy #	Group #

Medicare/Medicaid Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Gastroenterology Specialists of Dekalb, LLC for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Gastroenterology Specialists of Dekalb, LLC for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

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Patient Health Questionnaire

Date:_____

Name: _____

Date of Birth: _____**Age:**_____

Referring Physician/PCP: _____

Mode: ambulatory wheel chair stretcher

Do you need an interpreter? Yes ____ No____ If Yes, arranged?_____Refused: _____

Reason for visit today _____

Past Medical History *Check if you have a history of any problems listed below*

- ❑Heart failure
- ❑Heart attack
- ❑Irregular heart beat
- ❑Heart murmur
- ❑Antibiotics before dental work
- ❑High blood pressure
- ❑Diabetes
- ❑High Cholesterol
- ❑COPD/Emphysema/Asthma
- ❑Hypo/Hyperthyroid
- ❑Clotting disorder
- ❑Blood Transfusion
- ❑ DVT/PE
- ❑Anemia
- ❑Ulcers
- ❑Colon cancer
- ❑Colon polyps
- ❑Hepatitis
- ❑Ulcerative Colitis
- ❑Crohn's Disease
- ❑Irritable/spastic bowel
- ❑GERD/Reflux
- ❑Breast cancer
- ❑Prostate cancer
- ❑Uterine cancer
- ❑Kidney disease/Dialysis
- ❑Tuberculosis/PPD
- ❑HIV/AIDS
- ❑Arthritis/Rheumatoid
- ❑Stroke
- ❑Seizure Disorder
- ❑Depression
- ❑Anxiety
- ❑Endometriosis
- ❑Sleep apnea
- ❑Other cancer_____
- ❑Other_____

Past Surgical History *Check if you have had any of the surgeries below and list year of your surgery*

- ❑Gallbladder removal_____
- ❑Appendectomy_____
- ❑Colon or bowel resection_____
- ❑Ulcer surgery_____
- ❑Artificial Joint_____
- ❑Heart bypass_____
- ❑Artificial heart valve_____
- ❑Coronary Stent_____
- ❑Upper Endoscopy _____
- ❑Mastectomy/Lumpectomy_____
- ❑Hysterectomy_____
- ❑Ovary removal_____
- ❑C-Section_____
- ❑Tubal ligation_____
- ❑Hernia Repair_____
- ❑Hemorrhoid removal_____
- ❑Colonoscopy _____
- ❑Other

_____

Current Medications *Include **prescription, over the counter, home and herbal remedies***

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication and Food Allergies *Include type of reaction* ❑ No known allergies

_____ _____

Family Medical History *Check if a blood relative has had a history of any problem listed below*

- ❑Heart Disease
- ❑High Blood Pressure
- ❑Diabetes
- ❑Breast Cancer
- ❑Uterine Cancer
- ❑Other_____
- ❑Colon Cancer
- ❑Colon Polyps
- ❑Ulcers
- ❑Ulcerative Colitis
- ❑Crohn's Disease
- ❑ Stomach Cancer
- ❑Liver Disease
- ❑Pancreatic problem
- ❑Gallbladder problem
- ❑Anemia
- ❑Other_____
- ❑Other_____

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Social History

Smoking: ❑None now ❑None ever
Currently how many/day? _____ # of years? _____
In past how many/day? _____# of years? _____
When did you quit? _____

Alcohol: ❑None now ❑ None ever
How many cocktails/beer/wine_____ daily/weekly/monthly/yearly (Circle one)

Cups of coffee/day_____ Caffienated soft drinks/day_____

History of recreational drug use? ❑None IV drugs_____ Intranasal_____ Other_____

Occupation _____ ❑ Disabled ❑ Retired ❑ Unemployed

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Domestic partnership

Children ages and health_____ _____

Review of Systems

Check symptoms you are currently having or have had in the last 3 months

❑Fatigue
❑Weight loss-unintended
❑Weight gain
❑Fever

❑Rash
❑Itching
❑Jaundice/Yellowing of eyes

❑Swelling in neck
❑Sores in mouth
❑Ringing in ears
❑Vertigo
❑Difficulty hearing
❑Nose bleeds
❑Pain in throat
❑Hoarseness
❑Glaucoma/Cataracts

❑Cough
❑Shortness of breath
- ❑-with exertion
- ❑-when laying down
- ❑-at night when sleeping

❑Wheezing

❑Chest pain
❑Swelling in legs
❑Pain in calf when walking

❑Nausea
❑Vomiting
❑Loss of appetite
❑Heartburn
❑Pain when swallowing
❑Food sticking in chest
❑Abdominal pain
- ❑-after eating
- ❑-before eating
- ❑-at night

❑Abdominal bloating/swelling
❑Diarrhea
- ❑-at night

❑Constipation
❑Blood in stool
❑Oily stools
❑Rectal pain/pressure
❑Leakage of stool

❑ Loss of bladder control
- ❑-when coughing/laughing

❑Burning with urination
❑Frequent urination
❑Blood in urine
❑Urinating at night

❑Easy bruising

Men:
- ❑-Slow urine stream
- ❑-Difficulty with erection

Women:
- ❑-Last period_____
- ❑-Irregular periods
- ❑-Heavy menstrual bleeding
- ❑-Painful intercourse

❑Joint pain/swelling

❑Nervousness
❑Depression
❑Insomnia

❑Blackouts
❑Headaches
❑Difficulty speaking
❑Tremors

❑Loss of body hair
❑Increased thirst
❑Heat or cold intolerant

❑Other _____
❑Other_____

❑ All others negative

Patient signature_____ MD/PA signature_____

Date_____ Date_____

Shirley A. Harris, MD
Kavitha Gopal, MD
Joanne G. Beer, PA-C

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY GASTROENTEROLOGY SPECIALISTS OF DEKALB AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this Notice please contact our Privacy Officer who is Leslie A Harris

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. **Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. **Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations are usually required and/or permitted by law and may include disclosure to/for: **public health agencies, persons if there is risk of contracting communicable diseases, health oversight agencies, Food and Drug Administration, judicial proceedings, law enforcement agencies, coroners, funeral director, organ donors organizations, national security agencies, worker's compensation programs.**

Other uses and disclosures of your protected health information will be made only with your written authorization.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Gastroenterology Specialists of Dekalb

Shirley A. Harris, MD
Kavitha Gopal, MD
Joanne G. Beer, PA-C

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. **You have the right to request a restriction of your protected health information**. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. **You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information**. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. **You have the right to obtain a paper copy of this notice from us**. You may request a copy even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Leslie A Harris at (404) 294-8180 **Ext 115**, lharris@gastrospecialists.com for further information about the complaint process.

This notice was published and becomes effective on **April 25th 2013.**

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

We are pleased that you have selected our practice as your healthcare provider. We are committed to providing you with compassionate and quality gastroenterology care. We regard your complete understanding of your financial responsibility as an essential element of your care and treatment. We have therefore adopted the following Financial Policy to reduce confusion and misunderstanding between our patients and practice.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience our practice accepts Visa, MasterCard, American Express and Discover credit cards, Debit Cards, Cash and Personal Checks.

Shirley A. Harris, MD
Kavitha Gopal, MD
Joanne G. Beer, PA-C

Insurance & Assignment of Benefits
We accept assignment of benefits for most insurance plans. Please provide any current medical insurance cards that should be used to cover services rendered. **We require that all co-payments, co-insurance and deductibles be paid at the time of service. In the case of procedures these should be remitted to the practice upon notice of balance due, at least 72 hours prior to the procedure.** By signing below, you assign all medical and surgical benefits, to include major medical benefits to which you are entitled. You hereby authorize and direct your insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Gastroenterology Specialists of Dekalb LLC** for medical services rendered to yourself and/or your dependents regardless of your insurance benefits, if any.

Your insurance policy is a contract between you and your insurance carrier. You are therefore responsible for determining what services your insurance company covers, as well as providing our practice with the correct insurance information. In the event that your insurance company declines the insurance claim for services rendered by Gastroenterology Specialists of Dekalb, LLC, you will be responsible for those charges. We recommend that you follow-up with your insurance carrier to assure yourself that payment will be made.

Missed Appointments: Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your office visit appointment, please kindly give a 24-hour notice. **Appointments cancelled without notice may result in a $35.00 missed office visit appointment charge.** Appointments for procedures will need to be cancelled 72 hours prior to the appointment. **Appointments cancelled for procedures without notice may result in a missed appointment charge of $200.00.** These charges are the responsibility of the patient and are not covered by insurance carriers.

Statements of Account: Statements detailing the balance due from patients will be mailed at least once per month. Payment for balances due is expected within 30 days of the statement date. It is our policy to use an outside collection agency to assist us in collecting delinquent accounts.

Returned checks: Checks returned for insufficient funds will result in a charge to your account for the amount of the returned check plus an additional $30.00 to recover returned check charges and expenses incurred.

Forms & Medical Records: Our practice is often requested to complete Disability, Life Insurance and other forms which contain detailed medical history questionnaires and require review by a physician. The charge for this service is $35.00 and is payable upon request, therefore forms will not be completed unless payment is received. There will be a charge of $30.00 for uncertified medical records and $35.00 for certified medical records.

I acknowledge that I have read and understood the privacy practices and the financial policy, I agree to abide by the financial policy of Gastroenterology Specialists of Dekalb, LLC and I assign benefits to the practice as described above.

X _____ _____
Signature of Patient or Responsible Party Date

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www.gastrospecialists.com