GASTROENTEROLOGY PRACTICE ASSOCIATESCPATIENT REGISTRATION

Please Print Clearly

Patient's Name:_____ SS #: _____

Date of Birth:_____□ Male □ Female □ Single □ Married □ Widowed □ Divorced □ Separated

Street Address:_____ **Email:** _____

City/State/Zip Code:_____ Home Phone w/Area Code:( ) _____-_____

Cell Phone w/Area Code:( )_____-_____Work Phone w/ Area Code:( )_____-_____

PLEASE LIST YOUR PREFERRED PHARMACY – Address is required.

Pharmacy Name: _____

Address / Cross Streets: _____

Phone Number: _____ **Fax Number:** _____

** Please provide all information requested above before proceeding. **

Race: o American Indian or Alaska Native ☐ Asian ☐ African American ☐ Native Hawaiian or Other Pacific Islander
☐ White/Caucasian ☐ Other ☐ Unknown ☐ Patient declines to provide

Ethnicity: o Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Emergency Contact/ HIPAA Contact

In case of emergency, contact Name: _____

Phone Number w/Area Code:( )_____-_____ **Relationship to Patient** _____

The emergency contact listed above is not an authorized HIPAA representative.
Please complete the authorized representative section to include your approved HIPAA contact.

Referring Physician's Name: _____ Phone: _____

Primary Care Physician Name: _____ **☐ Same** Phone: _____

Do you have an advanced directive or living will? Please Circle: Yes or No

PLEASE PROVIDE INSURANCE INFORMATION BELOW

Primary Insurance Name: _____

>>Primary Insured's Name:_____ **>>Date of Birth:**_____

Primary Insured's Social Security#: _____ **Relationship:** _____

Policy #:_____ Group #: _____

Secondary Insurance Name: _____

>>Primary Insured's Name:_____ **>>Date of Birth:**_____

Primary Insured's Social Security#: _____ **Relationship:**_____ **Policy #:**_____ **Group #:**_____

If you are a follow up patient, seen in the last 6 months, and there have been no changes, please sign & date.

Patient Name: _____Signature: _____ Date: _____

Gastroenterology Practice Associates

CONSENT TO TREAT

- I hereby authorize the payment of medical benefits to Gastroenterology Practice Associates for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and any other costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize Gastroenterology Practice Associates to release any medical information necessary to complete and process my insurance claims.
- I hereby authorize Gastroenterology Practice Associates to treat me and use my personal health information for healthcare operations

_____ _____

Signature of Patient or Legal Guardian ***Date***

(If patient is a minor, must have responsible party signature)

CANCELLED/RESCHEDULED APPOINTMENT POLICY

- All patients will be required to provide a **24-business hour** notice to cancel or reschedule any office appointment. Failure to provide the required **24- business hour** notice will result in a $75 fee. Patients that are more than 15 minutes late to their appointment are also subject to $75 fee and will be asked to reschedule appointment.
- All in-office or facility procedures will require a **72- business hour** notice to cancel or reschedule the procedure. Failure to provide the required **72- business hour** notice will result in a $100 fee.
- Payment of the fees for cancelled or rescheduled appointments will be required to be paid in full prior to any future appointment or procedures being conducted.
- After 4 or more cancellations or no shows, GPA may choose to terminate your care due to the inability to maintain an adequate patient/provider relationship.
- I understand that GPA does have an afterhours on call service that I may utilize. The number for this is 817-468-7200.

_____ _____

Signature of Patient or Legal Guardian ***Date***

(If patient is a minor, must have responsible party signature)

HIPAA PRIVACY PRACTICES

(A copy of the HIPAA Practices is located at the front desk. If you would like a copy to keep, please ask the receptionist.)

- By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Gastroenterology Practice Associates, PLLC.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information and your rights related to the use and disclosure of your protected health information. We encourage you to read it in full.
- Our *Notice of Privacy Practices* is subject to change. If we change our notice, a notice will be posted in the office and on our website. You may obtain a copy of the revised notice by asking the staff at the reception desk in the Gastroenterology Practice Associates office at 301 Highlander Blvd. Ste 121, Arlington, TX 76018, or calling 817-468-7200.
- If you have any questions about our *Notice of Privacy Practices*, please contact: Privacy Officer, Gastroenterology Practice Associates at 301 Highlander Blvd. Ste 121, Arlington, TX 76018 or call 817-468-7200

I acknowledge receipt of the *Notice of Privacy Practices* of *Gastroenterology Practice Associates, PLLC.*

Print Name: _____ Signature: _____Date: _____

Authorized Representatives

As a patient of Gastroenterology Practice Associates, I understand that there may be occasions where the office staff may need to contact me regarding appointments, the scheduling of tests, test results, medications, etc. In such event, I am unavailable; I authorize Gastroenterology Practice Associates to discuss my medical record (including test results and plan of care) with the following individuals. This authorization also includes the leaving of voicemail messages on my home, work, and/or cell phone. I give Gastroenterology Practice Associates permission to discuss my personal health information as stated above with the following individuals:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

- ❑ I do not wish to provide an authorized representative.

_____ _____

Patient Signature ***Date***

BILLING POLICY

- I understand that it is my responsibility to provide the Gastroenterology Practice Associates office with current, accurate billing information at the time of check-in and to notify Gastroenterology Practice Associates of any changes in this information.
- **I understand that it is my responsibility to know my specialist co-pay** (which can be different than my primary care co-pay) and to pay it at the time services are rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service. Gastroenterology Practice Associates is required to report to the carrier any enrollees failing to pay their co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account, I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- I understand that there is a **$75 fee** to complete disability paperwork (including FMLA) associated with my care. A standard form can be requested free of charge. If additional disability forms require completion, I understand that an additional $75 fee (payable prior to completion) is required. The $75 fee also applies to the renewal of disability paperwork. Completion of the disability paperwork is at the provider's discretion.
- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the third statement will be marked as "Final Notice" and will be sent to an outside collection service if I do not fulfill my financial obligations. **I understand that if my account is turned over to a collection agency, a $75 service charge will be added to the balance.**
- I understand that Gastroenterology Practice Associates will attempt to obtain the necessary prior authorizations prior to rendering treatment. I understand that ensuring prior authorization has been obtained is my responsibility and not the responsibility of Gastroenterology Practice Associates. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that my balance must be paid in full to proceed with my appointment. GPA does not typically discuss billing issues in office, and I will need to call the billing department to discuss any discrepancies.

_____ _____

Signature of Patient or Legal Guardian ***Date***

(If patient is a minor, must have responsible party signature)

GASTROENTEROLOGY PRACTICE ASSOCIATES - SYMPTOM SURVEY

MEDICAL HISTORY / CONDITION (Check all that apply)

☐ Acid Reflux Disease/GERD
☐ AIDS / HIV Positive (Circle)
☐ Anemia (Diagnosed by a physician)
☐ Arthritis / Osteoarthritis (Circle)
☐ Asthma
☐ Barrett's Esophagus
☐ Cancer (What Type) _____
☐ Celiac Disease
☐ Chemical Dependency
☐ Crohn's Disease
☐ Diabetes – Type I or Type II (Circle)
☐ Diverticulitis / Diverticulosis (Circle)
☐ Emphysema
☐ Epilepsy / Seizures (Circle)
☐ Fatty Liver
☐ Heart Disease: Cardiologist_____
☐ Hemorrhoids
☐ Hepatitis A / B / C (Circle)
☐ High Blood Pressure
☐ High Cholesterol
☐ History of Colon Polyps
☐ History of H. Pylori Infection
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Liver Cirrhosis
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Prostate Disease
☐ Psychiatric Care
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke / Heart Attack (Circle)
☐ Thyroid Disease – Overactive / Underactive (Circle)
☐ Ulcerative Colitis
☐ **Other**: _____

PAST SURGICAL HISTORY

(List all surgeries / procedures you have had and the **year**)

1. _____Yr. _____
2. _____Yr. _____
3. _____Yr. _____
4. _____Yr. _____
5. _____Yr. _____
6. _____ Yr. _____
7. _____ Yr. _____
8. _____ Yr. _____
9. _____Yr. _____
10. _____Yr. _____

Date of Last Upper Endoscopy: _____ **Performing Dr.** _____
Date of Last Colonoscopy: _____ **Performing Dr.** _____
Polyps Removed? ☐YES ☐NO

CURRENT MEDICATIONS WITH DOSAGE

1. _____MG _____
2. _____MG_____
3. _____MG_____
4. _____MG_____
5. _____MG_____
6. _____MG_____
7. _____MG_____
8. _____MG_____
9. _____MG_____
10. _____MG_____
11. _____MG_____
12. _____MG_____
13. _____MG_____
14. _____MG_____
15. _____MG_____
16. _____MG_____

DRUG ALLERGIES

_____ _____
_____ _____

PAST HOSPITALIZATIONS **REASON** AND THE **YEAR**

_____YR _____ _____YR_____
_____YR_____ _____YR_____

FAMILY HISTORY (Do not list family member names)

List any known illnesses, cancers or conditions

Mother: _____ ☐Alive ☐ Deceased
Father: _____ ☐Alive ☐ Deceased
Siblings: _____ ☐Alive ☐ Deceased
Maternal GM: _____ ☐Alive ☐ Deceased
Maternal GF: _____ ☐Alive ☐ Deceased
Paternal GM: _____ ☐Alive ☐ Deceased
Paternal GF: _____ ☐Alive ☐ Deceased

If you are a follow up patient, seen in the last 6 months, and there have been no changes, please sign & date.

Patient Signature: _____ Date: _____

Instructions: Please check YES to symptoms you are <u>currently</u> experiencing and NO to symptoms you are not feeling <u>today or within the past week.</u>

NEUROLOGICAL

□ Yes □ No Fatigue (sluggish, tired)
□ Yes □ No Restlessness at Night
□ Yes □ No Seizures

EMOTIONAL/MENTAL

□ Yes □ No Depression
□ Yes □ No Anxiety
□ Yes □ No Mood Swings
□ Yes □ No Lack of Concentration/Focus
□ Yes □ No Stress

HEAD/EARS/EYES

□ Yes □ No Headaches (any kind)
□ Yes □ No Decreased Hearing
□ Yes □ No Glaucoma

NASAL/SINUS

□ Yes □ No Post Nasal Drip
□ Yes □ No Sinus Pain
□ Yes □ No Stuffy Nose

SOCIAL HISTORY, PART I

□ Yes □ No Do you smoke?
If yes, how many packs per day? _____
How many years? _____
If Quit, When? _____

□ Yes □ No Have you ever traveled outside the US within the past year?
If Yes, Where? _____
_____

MOUTH/THROAT

□ Yes □ No Sore Throat
□ Yes □ No Swollen Throat
□ Yes □ No Swelling of Lips/Tongue
□ Yes □ No Gagging / Choking
□ Yes □ No Lesions ("Canker Sores")
□ Yes □ No Difficulty Swallowing
□ Yes □ No Painful Swallowing
□ Yes □ No Chronic Belching

LUNGS

□ Yes □ No Wheezing
□ Yes □ No Chest Congestion
□ Yes □ No Non-Productive Coughing
□ Yes □ No Productive Coughing

GENITOURINARY

□ Yes □ No Increased Urinary Frequency
□ Yes □ No Painful Urination
□ Yes □ No Blood in Urine
□ Yes □ No Lack of Bladder Control

SOCIAL HISTORY, PART II

□ Yes □ No Do you drink alcohol?
If Yes, What Type? Liquor Beer Wine
How Often? _____
How Many Glasses Per Occasion?
_____

□ Yes □ No Have you ever had a blood transfusion?
If yes, When? _____

□ Yes □ No Do you have history of Drug Use?

MUSCULOSKELETAL

□ Yes □ No Joint Pains/Aching
□ Yes □ No Muscle Aches

GASTROINTESTINAL

□ Yes □ No Heartburn/Indigestion
□ Yes □ No Abdominal Pain
□ Yes □ No Constipation
□ Yes □ No Diarrhea
□ Yes □ No Bloating Sensation
□ Yes □ No Excessive Flatulence
□ Yes □ No Nausea
□ Yes □ No Vomiting
□ Yes □ No Painful Elimination
□ Yes □ No Poor Appetite
□ Yes □ No Chills
□ Yes □ No Fever
□ Yes □ No Fecal Incontinence
□ Yes □ No Black/Tarry Stools
□ Yes □ No Change in Bowel Pattern
□ Yes □ No Blood in Stool
□ Yes □ No Rectal Pain/Pressure

WEIGHT MANAGEMENT

□ Yes □ No Binge Eating
□ Yes □ No Purging (all methods)
□ Yes □ No Excessive Weight Loss
□ Yes □ No Weight Gain

SOCIAL HISTORY, PART III

□ Yes □ No Do you drink caffeine?
If Yes, What Type?

TEA COFFEE SODA

How many cups per day? Please Circle
1 2 3 4 5 >5

Gastroenterology Practice Associates

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **Gastroenterology Practice Associates** to **SEND / RECEIVE** healthcare information of the patient named above **TO / FROM**:

Name: _____

Address: _____

City: _____State: _____Zip: _____

Fax (REQUIRED): _____ Phone (REQUIRED): _____

This request and authorization applies to:

- ❑ Healthcare information relating to the following treatment, condition, or dates:
  _____
  _____
- ❑ All healthcare information
- ❑ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed abo ve. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed abo ve.

Patient Signature: _____ Date: _____