CIG | Consultants in Gastroenterology pc

TEC | The Endoscopy Center inc

Date of Visit: ________________

☐New Patient ☐Update

☐Mr. ☐Mrs. ☐Ms. ☐Male ☐Female

Name: ____
Last First Middle

Address: ____
Street City State Zip

Social Security Number: ________________ Date of Birth:________________ Age: ________________

Ethnic Origin: ☐Hispanic ☐Non-Hispanic

Race: ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Multi-Racial ☐ Caucasian
☐ Native ☐ Hawaiian/Pacific Islander ☐ Refuse/Unknown ☐ Other

Religious Preference: ____

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

E-Mail Address: ____

Employer: ________________________ Occupation: ________________________

Employer's Address: ____
Street City State Zip

Marital Status: ________________________ Spouse: ________________________

Spouse's Employer: ____
Street City State Zip

In case of Emergency Contact: ________________________ Relationship: ________________

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

Referring Physician: ________________________ Is this a Worker's Comp Claim? ________________

Address: ____
Street City State Zip

Medical Insurance Information

Primary Care Company: ________________________ Telephone Number: ________________

Policy Number: ________________________ Certificate Number: ________________________

Group Number: ________________ Policy Holder: ________________ Relationship to Policy Holder: ____________

Policy Holder's Birthdate: ____________ Policy Holder's Social Security Number: ________________________

Secondary Insurance Company: ________________________ Telephone Number: ________________

Policy Number: ________________________ Certificate Number: ________________________

Group Number: ________________ Policy Holder: ________________ Relationship to Policy Holder: ____________

Policy Holder's Birthdate: ____________ Policy Holder's Social Security Number: ________________________

Responsible Party

☐Mr. ☐Mrs. ☐Ms.

Name: ____
Last First Middle

Address: ____
Street City State Zip

Responsible Party/Guarantor's Signature: ____

Authorization: I have read and agree to the terms and conditions and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits of the provider of services. This also includes authorization for Medicare. I understand I am financially responsible to Consultants in Gastroenterology, P.C./The Endoscopy Center, Inc. for charges not covered or denied by insurance company. **I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this require.**

Insured/Patient's Signature: ____

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A Division of Digestive Health Specialists

Acknowledgements

Receipt of Privacy Practice / Emergency Contact

I hereby acknowledge receipt of Digestive Health Specialists, LLC Notice of Privacy Practices and I give Digestive Health Specialists, LLC permission to disclose my protected health information to the individuals listed below:
**Who can we release medical information to (other than your doctor)? Please list name, phone number (including area code), and relationship

____

____

** Who would you like to list as an emergency contact? Please list, name, phone number (including area code), and relationship.

____

____

Patient Portal Consent

I give Digestive Health Specialists permission to contact me at the email address that is listed on my patient information form, regarding test results or any other healthcare information.

☐ I consent to the patient portal ☐ I decline the patient portal

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Photo Consent for Identification Purposes in the Patient Record

Please choose one option below:

☐ I consent to have my Photo taken ☐ I decline to have my Photo taken

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Financial Responsibility

Authorizations: I have read and agree to the terms and conditions and hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to the provider of services. This also includes authorization for Medicare. I understand I am financially responsible to Digestive Health Specialists, LLC / The Endoscopy Center Inc. for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to the cost of collection and /or court costs and reasonable fees should this be required.

The undersigned certifies that the patient has read and understands the information above and fully accepts all terms specified above.

Signature of Patient/Guardian____ Date ____________________________

These signatures will expire one year from date signed.

TEC | The Endoscopy Center inc

Acknowledgement of Patient Rights

Financial Responsibility

Authorizations: I have read and agree to the terms and conditions and hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to the provider of services. This also includes authorization for Medicare. I understand I am financially responsible to Digestive Health Specialists, LLC / The Endoscopy Center Inc. for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to the cost of collection and /or court costs and reasonable fees should this be required.

Patient Rights/Advanced Directives Information

I have received written and verbal notification regarding my patient rights prior to my procedure. I have also received information regarding policies pertaining to Advance Directives prior to my procedure. Information regarding Advanced Directives, along with official State documents have been offered to me upon request.

Do you have a Living Will or Advanced Directive? ☐ Yes ☐ No

The undersigned certifies that the patient has read and understands the information above and fully accepts all terms specified above.

Signature of Patient/Guardian____ Date ___________________________

The Independence ASC
❑ 3800 South Whitney, Independence, MO 64055
❑ 5330 North Oak Trafficway, Kansas City, MO 64118
❑ 9601 NE 79th Street, Kansas City, MO 64158

Patient Name: ____________________________

Identification Number: _______________________

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare/Medicare Replacement doesn't pay for the Screening Colonoscopy below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Screening Colonoscopy below.

	Reason Medicare May Not Pay:	Estimated Cost:
Screening Colonoscopy	Medicare has guidelines for which they will pay for this test. Screening Colonoscopy: Once every 24 months (if you're at high risk); once every 10 years, but not within 48 months of a screening sigmoidoscopy (if you're not a high risk). **Medicare/Medicare Replacement may not pay for this test if you have had one prior to the guideline above.**	$940.00

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Screening Colonoscopy listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: **Check only one box. We cannot choose a box for you.**

❑ **Option 1.** I want the screening colonoscopy listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
❑ **Option 2.** I want the screening colonoscopy listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
❑ **Option 3.** I don't want the screening colonoscopy listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

For details and covered services, please refer to your Medicare Preventative Services for Benefits. You may also view these benefits on the Medicare & You website at http://www.medicare.gov/health/coloncancer.asp.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Consultants In Gastroenterology, P.C.
❑ 3800 South Whitney, Independence, MO 64055
❑ 5330 North Oak Trafficway, Kansas City, MO 64118
❑ 9601 NE 79th Street, Kansas City, MO 64158

Patient Name: ______________________________

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	Reason Medicare May Not Pay:	Estimated Cost:
Screening Colonoscopy	Medicare has guidelines for which they will pay for this test. Screening Colonoscopy: Once every 24 months (if you're at high risk); once every 10 years, but not within 48 months of a screening sigmoidoscopy (if you're not a high risk). **Medicare/Medicare Replacement may not pay for this test if you have had one prior to the guideline above.**	Estimate between $1,353.00 and $1,473.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Screening Colonoscopy listed above.

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❑ **Option 2.** I want the screening colonoscopy listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

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PATIENT HISTORY

Today's date_______________

PATIENT: ____________________________ REFERRING PHYSICIAN: _________________ AGE: _______ DATE OF BIRTH: __________

PATIENT PROFILE (CHECK ONE)

☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

OCCUPATION ______________________________________

HABITS: Tobacco Use: Y/N Amount per day: ___________
Alcohol Use: Y/N Amount per day: ___________
Caffeine Use: Y/N Amount per day: ___________
History of Drug Use ___________________________

Smoking status: ☐ never smoker ☐ former smoker
☐ current every day smoker ☐ current some day smoker

Last Colonoscopy: __________ Last Pap Smear: __________
Last EGD: ______________ Last Mammogram: ________
Last menstrual Period: _____________________________

Medical History and Recent Symptoms (Circle all that apply)

General
Fever
Sweats
Weight Loss/Gain
Loss of Appetite
Fatigue

Eyes/Ears/Nose/Throat
Blurring
Vision Loss
Nasal
Loss of Hearing
Bad Taste in Mouth
Sore Throat
Hoarseness
Sores in Mouth
Glaucoma

Cardiovascular
Chest pain
High Blood Pressure
High Cholesterol
Stents
Pacemaker/Defibrillator
Heart diagnosis
Swelling in extremities
Blood clots
Heart Murmur
Heart attack

Respiratory
COPD
Short of Breath
Asthma
Sleep apnea
C-Pap/Bi-Pap
Cough
Wheezing
Excessive Sputum

Gastrointestinal
Nausea
Vomiting
Diarrhea
Constipation
Change in Bowel Habits
Blood in stool
Jaundice
Abdominal Pain
Barrett's Esophagus
C-Diff Colitis
H pylori
Polyps
Difficulty Swallowing
Diverticulosis
Diverticulitis
Hemorrhoids
Ulcers
Ulcerative Colitis
Crohn's
Microscopic Colitis
Heartburn
Get Full Quickly at Meals
Abdominal distention
Gas/Bloating
Pain with Bowel Movement
Belching
Irregular Bowel Habits
Incontinence of Stool
Vomiting Blood
Hernia
Hepatitis A/B/C
Food/Milk Intolerance
Celiac Sprue
Other ________________

Reason for Today's visit: ______________________________

Medical History and Symptoms cont.

Neurologic
Stroke/TIA
Neuropathy
Seizures
Dizziness
Memory Loss
Tremors
Lack of Coordination
Restless Leg Syndrome

Psychiatric
Bipolar
Depression
Anxiety
Suicidal Thoughts
Emotional Problems

Endocrine
Diabetes
Last Blood Sugar ______
Cold Intolerance
Heat Intolerance
Thyroid Problems
Excessive Thirst
Lymph Node Swelling

Personal History of cancer
____
____

Skin
Rash
Itching

Genitourinary
Kidney/Bladder Infections
Kidney Stones
Incontinence
Enlarged Prostate

Hematologic
Bruising
Bleeding
Anemia

Allergic Immunologic
Persistent Infections
HIV Exposure
Seasonal Allergies

Musculoskeletal
Arthritis
Osteoporosis
Osteopenia
TMJ
Fibromyalgia

FAMILY HISTORY CANCER

Relative ________________ Cancer______________________
GI Cancers: ☐Colon ☐Esophagus ☐Liver ☐Pancreas
GI Illnesses: ☐Ulcers ☐Colitis ☐Crohn's ☐Celiac Sprue ☐Polyps

Surgeries
(Circle all that apply)
Appendix
Gall Bladder
Back/Spinal
Brain
Breast
Colon
Esophagus
Heart
Hemorrhoids
Cataracts
Hysterectomy
C-Section
Hernia/Groin
Joint Replacement
Laparoscopy
Prostate
Stomach
Tonsils
Tubal Ligation
Weight Loss Surgery
Stents
Pacemaker
Other Surgeries
____

PATIENT MEDICATION SHEET

Patient Name ______________________________ Date ____________

Pharmacy ______________________________ Pharmacy Phone Number: ____________

Mail Order Pharmacy: ______________________________

Allergies to medications AND reactions:

Please Print All Information

Also List All Medications, Supplements and Over-The-Counter Medications

Medication	**Dose/mg**	**How many times a day do You take your medication?**	**What do you take your Medication for?**
(example: Coumadin)	*(5mg)*	*(once daily)*	*(blood thinner)*
(example: Aleve)	*(200mg)*	*(as needed)*	*(headaches)*