Harold B. Harrison, M.D.
Carley S. Ebanks, M.D.
Adam Levy, M.D., FACG

GASTROENTEROLOGY ASSCIATES OF CENTRAL GEORGIA, LLC
610 THIRD STREET, MACON, GA 31201
478.464.2600

Shahriar Sedghi, M.D., AGAF
R. Brad Bedgood, D. O.

PATIENT DATA FORM MUST BE COMPLETED IN FULL **Today's Date** _____

Name _____ **Date of Birth** _____

Mailing Address _____

Street City State Zip

Phone Numbers Home _____ Cell_____ Work_____

Primary Phone is ❑ **Home** ❑ **Cell** ❑ **Work** **Can we text you?** ❑ Yes ❑ No

Primary Care Physician: _____ **Referring Physician:** _____

Gender ❑ Male ❑ Female **Marital Status** ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Social Security # _____

Employer _____ **Dept. | Title** _____ **Occupation** _____

Employer's Address _____

Street City State/Zip

Employer's Phone Number _____ **Extension** _____

Email Address _____

Race _____ **Ethnicity** _____ **Language** _____

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you

_____

Name/ Relationship Phone Date of Birth

Nearest relative or friend not living with you

_____

Name/ Relationship Phone Date of Birth

INSURANCE INFORMATION (We do need you to write your insurance information even if we have a copy of your cards)

PRIMARY Company _____Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

SECONDARY Company _____Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address_____

Street City State/Zip

I authorize Gastroenterology Associates, LLC to obtain my prescription history electronically. ❑ Yes ❑ No

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of GAOCG, LLC and its affiliates this includes services provided by a Physician Assistant or Nurse Practitioner under the supervision of a GAOCG physician. I understand that I may ask for any medications prescribed by the Physician Assistant or Nurse Practitioner to be reviewed by a physician prior to having the prescription filled. I authorize payment of medical benefits to GAOCG, LLC and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient / Guarantor Signature* _____ Date _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Patient Name _____ Date of Birth _____

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ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that GAOCG, LLC, has given me the opportunity to read a detailed notice of their Privacy Practices. A Copy of Privacy Practices are posted in the lobby and a copy can be requested at the front desk.

_____ _____

Patient/Authorized Representative Signature Date

If not signed, please provide a reason why the acknowledgement was not obtained.

_____ _____

Witness / Staff Signature Date

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from GAOCG, LLC, to share information regarding care or tests results with the individuals listed below. These individuals may also request protected health information on my behalf.

_____

Name Phone Relationship/Date of Birth

_____

Name Phone Relationship/Date of Birth

_____

Name Phone Relationship/Date of Birth

Is it OK to leave results or information on your voicemail? ❑ Yes ❑ No

_____ _____

Patient/Authorized Representative Signature Date

CONSENT TO CORRESPOND ELECTRONICALLY

While GAOCG, LLC, takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication. I acknowledge that if I use electronic mail to initiate contact with a GAOCG provider regarding medical care, the GAOCG physician and/or his/her representative has my permission to correspond via that email address. I give permission for a GAOCG physician or clinical staff member to email me at @ _____ regarding medical care.

_____ _____

Patient/Authorized Representative Signature Date

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Financial Disclosure Statement

Thank you for choosing GAOCG, LLC. Please read and sign this **Financial Disclosure Statement** prior to your appointment. Patients who do not pay in full at the time of service, must complete the required information and insurance forms before services will be rendered.

- You can expect to receive the following bills: **Physician Fee**: Fee paid to the physician for performing the service. This bill will be from GAOCG, LLC. **Lab Fee:** If a lab test is ordered, a separate bill will come from a lab or a radiologist. **Endoscopy Fee:** If a procedure is performed at the Endoscopy Center of Middle Georgia, LLC, a separate bill will come from the Endoscopy Center of Middle Georgia, LLC.
- Some insurance companies require pre-certification for this service. We will make every effort to verify your benefits and obtain any necessary pre-cert prior to your appointment. This is not a guarantee of payment.
- Your insurance company will send you an **Explanation of Benefits** that will explain how your bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand your insurance benefits.
- Some insurance plans require you to pay different **out-of-pocket** amounts based on the location where the service is performed. **Deductibles**, **co-insurance** and **co-payments** may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as, any non-covered services outlined in your health plan. We will submit primary, secondary, and tertiary claims on your behalf when the information needed to process the claim is obtained and verified before your visit. **If this information is obtained after your visit or if the information provided is deemed inactive for the dates of service, the patient or guarantor is responsible for the balance.**
- We accept cash, checks, and major credit cards. GAOCG, LLC, collects **co-payments** at the time of service. Additional payment may be required based on your insurance plan. For additional questions regarding billing or payment arrangements, call the Central Business Office at 478-464-2600, option 1 for Business Office. **A $30.00 fee will be incurred for returned checks.**
- **Cancellation Fee:** If you are unable to keep your appointment, please reschedule at least 24 hours in advance. A missed appointment will result in a $25.00 fee. A $50.00 fee will be incurred after (3) missed appointments. Multiple, consecutive missed appointments will result in a discharge from the practice due to noncompliance. **If you must cancel or reschedule your procedure, please call as early as possible**. We require at least 48 hour notice of any change to your scheduled procedure or you could be subject to a $100.00 missed procedure fee. Multiple missed procedure appointments will result in being discharged from the practice due to non-compliance.
- **Medicare Authorization:** I request that payment of authorized Medicare benefits be made on behalf of GAOCG, LLC for any of the services furnished. I authorize any holder of medical information about me to release to the Healthcare Financing Admin and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. GAOCG, LLC agrees to accept the charge determination of the Medicare carrier as the full charge. The Patient is only responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are decided by the Medicare carrier.

Patient's Reassignment and Release Statement By signing below, I understand the billing practices of GAOCG, LLC. I may receive multiple bills related to my service as explained above. I authorize payment of medical benefits to GAOCG, LLC and authorize them to release any medical information necessary to process claims. I give GAOCG, LLC permission to apply payments received to balances due at GAOCG, LLC. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan

_____ _____

Patient/Authorized Representative Signature Date

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Name _____ Age_____ Date of Birth _____

Referred by _____ Primary Care Physician_____

Other physicians involved in your healthcare _____

Describe the reason(s) for your visit _____

_____

1) Have you been out of the country in the last 6 months? ❑ **Yes** ❑ **No**

2) PATIENT MEDICAL HISTORY **Check all that apply**

- ❑ Cirrhosis
- ❑ Colon Cancer
- ❑ Colon Polyps
- ❑ Crohn's Disease
- ❑ Diverticulitis
- ❑ Diverticulosis
- ❑ End Stage Renal Disease(ESRD)
- ❑ GERD
- ❑ Hepatitis B
- ❑ Hepatitis C (HCV)
- ❑ Hiatal Hernia
- ❑ Cancer: Type _____
- ❑ Irritable Bowel Syndrome
- ❑ Liver Disease
- ❑ Stomach/Intestinal Ulcers
- ❑ Ulcerative Colitis
- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Other mental illness
- ❑ Arthritis/Osteoarthritis
- ❑ Asthma
- ❑ Cataracts
- ❑ Hypertension
- ❑ Congestive Heart Disease (CHF)
- ❑ COPD/Emphysema
- ❑ Coronary Artery Disease (CAD)
- ❑ Diabetes
- ❑ Glaucoma
- ❑ HIV/AIDS
- ❑ Hyperlipidemia/High Cholesterol (HLD)
- ❑ Chronic Kidney Disease (CKD)
- ❑ Hypothyroidism
- ❑ Migraines
- ❑ Myocardial Infarction/ Heart Attack
- ❑ Nerve/Muscle Disease
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pancreatitis
- ❑ Seizures
- ❑ Stroke (CVA)
- ❑ Sleep Apnea

❑ Other _____

****Have you had any falls within the last year?** ❑ Yes ❑ No If yes, when: _____

3) VACCINES

Have you ever had any of the following vaccines? ❑ Influenza (Flu) ❑ Hepatitis A ❑ Hepatitis B ❑ Pneumococcal vaccine

❑ Other _____

4) SURGICAL HISTORY **Check all that apply and provide dates**

- ❑ Colon Surgery _____
- ❑ Colonoscopy _____
- ❑ Hemorrhoid Surgery _____
- ❑ Gallbladder Surgery _____
- ❑ Gastric Surgery _____
- ❑ Heller Myotomy _____
- ❑ Liver Surgery _____
- ❑ Reflux Surgery _____
- ❑ Small Intestine Surgery _____
- ❑ Upper Endoscopy (EGD) _____
- ❑ Laparotomy _____
- ❑ Appendectomy _____
- ❑ Brain Surgery _____
- ❑ Breast Surgery _____
- ❑ C-Section _____
- ❑ CABG/Heart Surgery _____
- ❑ Defibrillator _____
- ❑ Hernia Surgery _____
- ❑ Hysterectomy _____
- ❑ Joint Replacement _____
- ❑ Obesity Surgery _____
- ❑ Pacemaker _____
- ❑ Prostate Surgery _____
- ❑ Spinal Surgery _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Transplant Surgery _____
- ❑ Tubal Ligation _____
- ❑ Valve Replacement _____
- ❑ Vasectomy _____
- ❑ Other _____

Name _____ Date of Birth _____

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5) MEDICATIONS (if you have a list please bring to front desk)
List Current Medications (including herbal) and Dosage

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you currently taking any of the following blood thinners? ❑ Coumadin ❑ Plavix ❑ Warfarin
❑Xarelto ❑Other _____

Are you currently taking any of the following aspirin/NSAIDs? ❑ Advil ❑ Aleve ❑ BC Powder
❑ Goody's Powder ❑ Ibuprofen ❑ Naprosyn
❑Other _____

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

6) HOSPITALIZATIONS Please list all past hospitalizations (please use a separate sheet if necessary):

_____

_____

_____

_____

_____

_____

7) ALLERGIES
List any medication or food allergies ❑ No known medication/food allergies

_____

_____

_____

_____

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8) FAMILY HISTORY (1st degree relatives) Check all that apply

	Mother	Father	Sister	Brother	Son	Daughter	Age at Diagnosis
Barrett's Esophagus	❑	❑	❑	❑	❑	❑	_____
Colon Polyps	❑	❑	❑	❑	❑	❑	_____
Crohn's Disease	❑	❑	❑	❑	❑	❑	_____
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	_____
Liver Disease	❑	❑	❑	❑	❑	❑	_____
Hyperlipidemia/ High Cholesterol (HLD)	❑	❑	❑	❑	❑	❑	_____
Diabetes	❑	❑	❑	❑	❑	❑	_____
Heart Disease/ Coronary Artery Disease	❑	❑	❑	❑	❑	❑	_____
Cancers							
○ Colon	❑	❑	❑	❑	❑	❑	_____
○ Esophagus	❑	❑	❑	❑	❑	❑	_____
○ Stomach	❑	❑	❑	❑	❑	❑	_____
○ Other (Specify)	❑	❑	❑	❑	❑	❑	_____
None of the Above	❑	❑	❑	❑	❑	❑	

9) SOCIAL HISTORY

Provide details regarding current and/or past used of the following:

Alcohol (beer, wine, liquor) ❑ Yes ❑ No Usage_____

I.V. or Recreational Drugs ❑ Yes ❑ No Usage _____

Tobacco (cigarettes, cigars, chewing tobacco) ❑ Yes ❑ No Usage _____

Smoking Status: ❑ Every Day ❑ Some Days ❑ Former ❑ Never

Tattoos: ❑ Yes ❑ No

Piercings: ❑ Yes ❑ No

Patient Signature _____ Date_____

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IMPORTANT INFORMATION ABOUT GRAChIE

What is GRAChIE (Prounounced GRACIE)? The Georgia Regional Academic Community Health Information Exchange (GRAChIE) is a network that connects practitioners and healthcare settings across Georgia, all of whom have made the decision to participate for one reason—to improve patient care. Across the country, networks like GRAChIE, (known as Health Information Exchanges or HIEs) are being formed. Their purpose is to allow doctors, nurses, and other healthcare provides to share vital information securely and electronically, reducing the need for patients to relay their medical information to every health professional involved with their care. Currently, your health information may be shared by telephone, fax, or mail. These isolated methods take time and can be burdensome on you or your providers. Additionally, they may fail to provide complete information.

Why is GRAChIE important? This network is an effort to streamline the healthcare process. If every doctor and hospital in Georgia has access to your medical records, they can see your medical history—including medications, diagnosis and conditions, allergies and immunizations.

This is especially critical in a crisis—and when you're traveling. For example if you're visiting Augusta from Macon and need emergency medical treatment, the Augusta doctors can access your Macon medical records.

YOUR HEALTH INFORMATION IS SECURE: Providers participating in GRAChIE will have **secure** access to your health information. All access by participating providers is on a **need-to-know** basis for treatment purposes **ONLY**. (***A listing of all participating providers can be found at GRAChIE.org)***.

SENSITIVE INFORMATION IS PROTECTED: Participating providers will share general health information. Sensitive health information—such as information related to mental health treatment—will **NOT** be shared through GRAChIE.

GRAChIE and all participating providers use a combination of safeguards to protect your health information. All providers must abide by policies that govern protection of health information. In addition, providers must abide by both federal and state laws related to privacy. There are also technical safeguards in place to ensure that your health information is secure, and your privacy is protected.

Am I required to participate in GRAChIE? No, you're not required. Patients are automatically opted in, but if you choose to opt out, you can request a pamphlet from our front desk and mail it in, or you can go online to *GRAChIE.org* and fill out the online form. *(Please allow up to ten (10) business days for your opt-out request to be processed).* If you decide to participate in GRAChIE now, and change your mind later, you can opt-out. Likewise, if you opt-out now, you can opt-in later and all of your medical information will be available.

For more information:
Call GRAChIE (478-553.2498)
Visit the website (www.GRAChIE.org)
Talk to your participating provider

I have read the above information and understand that unless I opt-out of GRAChIE, I am automatically opted-in.

_____ _____

Patient Signature Date