GI PHYSICIANS, INC

Phone: 419-228-2600

Fax: 419-228-1100

LAST NAME: ________________________________FIRST NAME: ________________________________ MIDDLE INTIAL: _____

SOCIAL SECURITY NUMBER: _______________________ RACE: ___________________ ETHNICITY: ________________________

ADDRESS: ____________________________________ CITY: _________________________ STATE: __________ ZIP: ____________

HOME PHONE __________________ WORK PHONE:_______________ CELL PHONE: _____________________

REFERRING PHYSICIAN: _________________________ FAMILY PHYSICIAN (if different than referring):________________________

DATE OF BIRTH: ______________ AGE: _____ MARITAL STATUS: _______________ PREFERRED LANGUAGE:_________________

How did you hear about our office?______________________________

EMERGENCY CONTACT (other than spouse)

NAME: _________________________________ RELATIONSHIP: ________________________ PHONE#:______________________

HEALTH INSURANCE: PLEASE BRING CARD(S) TO YOUR APPOINTMENT

PRIMARY INSURANCE NAME: _____________________________ PRIMARY HOLDER: _______________________________

PRIMARY HOLDER'S D.O.B.:_________________ EMPLOYER: _________________________ EMPLOYER PHONE: __________________

EMPLOYER ADDRESS: _____________________________ CITY: __________________________ STATE: ________ ZIP: ____________

CERTIF/ID#:_______________________ GROUP#________________________ INSURANCE PHONE#:__________________________

INSURANCE ADDRESS: _____________________________ CITY: ______________________ STATE: ____________ ZIP: ____________

SECONDARY INSURANCE NAME: _________________________ SECONDARY HOLDER: _____________________________

SECONDARY HOLDER D.O.B.:_____________ EMPLOYER: __________________________ EMPLOYER PHONE: _________________

EMPLOYER ADDRESS: ______________________________ CITY: ______________________ STATE: ________ ZIP: ______________

CERTIF/ID#:________________________ GROUP#:_______________________ INSURANCE PHONE#:__________________________

INSURANCE ADDRESS: _______________________________ CITY: _______________________ STATE: ________ ZIP: ____________

I hereby consent GI Physicians, Inc. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to the physician(s) rendering the covered services. I authorize GI Physicians, Inc., to furnish complete information to my insurance carrier or its intermediaries regarding services rendered. I understand I am financially responsible for all charges not covered by this consent.

I have read (and understand) the payment information. I also give permission to GI PHYSICIANS, INC to use/disclose personal health care information for treatment, payment and/or health care operations.

Signature____ Date ______________________________

I consent my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communications to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Signature____ Date ______________________________

GI PHYSICIANS, INC.

FOR WHAT PROBLEM ARE YOU SEEKING CARE? ____

IF PAIN IS PRESENT, PLEASE DESCRIBE: _____________________HOW OFTEN: ___________________

SEVERITY (1 MINIMAL-10 SEVERE):______HOW LONG HAS THIS PROBLEM BEEN PRESENT? _____________

QUALITY (i.e. sharp, dull, crampy, burning, achy, etc.)____

DOES THE PAIN MOVE ANYWHERE? ____

WHAT MAKES PAIN BETTER? _____________________________ WORSE: __________________________

WEIGHT CHANGE IN THE PAST 6 MONTHS:

Weight Gain: _______ Weight Loss: _______ HEIGHT: _________ WEIGHT: __________

Have you ever had or been treated for: (Circle the problem concerned)

General: Fever, chills, weight loss, night sweats.

Eyes: Cataracts, double vision, glaucoma, pain on exposure to light, loss of vision.

Ear, Nose, **Throat:** Hearing loss, sinus infections, nasal polyps, hoarseness.

Cardiovascular: High blood pressure, heart disease, heart murmur, angina, chest pains, rheumatic fever, defibrillator.

Respiratory: Pleurisy, TB, coughing up blood, asthma, emphysema, bronchitis, shortness of breath, chronic cough.

Gastrointestinal: Swallowing trouble, heartburn, belching, gas, duodenal or gastric ulcer, abdominal pain, liver disease, jaundice, hepatitis, gallbladder disease, constipation, diarrhea, black stools, blood in stools, change in bowel habits, incontinence (loss of control of bowel movements).

Genitourinary: Kidney or bladder infections, blood in urine, kidney stones, nephritis, incontinence, prostate trouble, sexual problems, sexually transmitted disease, extramarital activity, homosexual activity.

Gynecologic: Abnormal menstrual bleeding, irregular periods, painful intercourse, frequent pelvic infections, endometriosis. List date of last menstrual period. _________________________________

Musculoskeletal: Painful or swollen joints, arthritis.

Skin and Breast: Rashes, psoriasis, melanoma, tattoos, breast lumps, breast cancer, skin cancer.

Neurological: Frequent headaches, migraines, epilepsy, seizures, passing out or dizzy spells, numbness or tingling of arms or legs, stroke.

Emotional: Sexual, physical or emotional abuse, depression, anxiety, excessive nervousness, marital problems, crying spells, suicidal thoughts, in-law problems.

Endocrine: Diabetes, thyroid disease.

Blood: Anemia, bleeding disorder, blood or blood product transfusion.

Allergic/Immunologic: Lupus, HIV (AIDS).

Cancer: Any previous cancers. Please list. ____

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Approximate Date of Last: Physical Exam_______________ Gallbladder_________________
Electrocardiogram_____________ Sigmoidoscopy_______________
Chest X-Ray_________________ Colonoscopy________________
Barium Enema_______________ GI Series____________________

Do you have a history of heart valve problems or need antibiotics before procedures?_____________
Please list your heart doctor's name and phone number____
List Drug Allergies____ None Known_______
Do you have a history of allergy or reactions to X-Ray dye or iodine? ___________________________
Are you sensitive or allergic to latex, iodine, tape, or shellfish?
____

List chronologically all operations and all hospitalizations (use separate sheet of paper if needed)

Approx Date	Operation and/or Diagnosis	Hospital	Physician

PLEASE BRING CURRENT MEDICATIONS WITH YOU

List all **medications/dosages taken**, when started and/if stopped including Motrin, Advil, Aleve, or all other "pain" meds, vitamins, laxatives, antacids, and birth control pills. **(Please use additional paper if needed)**
____

____

Tobacco:___pk(s)/day for___yr(s) Soft Drinks:____oz(s)/day
Alcohol: Type____________ Amount__________ Street Drugs_____________________________

FAMILY HISTORY

	Age	State of Health & Diagnosis	Age at Death and Cause
Father			
Mother			
Brother or Sister			
Brother or Sister			
Brother or Sister			

Father's Father			
Father's Mother			
Mother's Father			
Mother's Mother			

Spouse			
Son or Daughter			
Son or Daughter			
Son or Daughter			

Does anyone in your family have history of colon polyps____ or colon cancer_____? (Please check). If yes, please list how related____

GI PHYSICIANS, INC.

In these times of constant changes of health coverage, much confusion can arise in the area of insurance claims and payments. We have tried to lessen some of the frustration by providing the following information:

Our office will be happy to pre-certify outpatient procedures; however, you are responsible for checking with your insurance company regarding coverage and benefits. If you are scheduled for screening or preventative services, PLEASE VERIFY WITH YOUR INSURANCE CARRIER THAT SCREENING OR PREVENTATIVE SERVICES ARE A COVERED BENEFIT UNDER YOUR PLAN. Some insurance companies may not cover these types of services.

PAYMENTS: We accept cash, VISA/MasterCard, or check (please make payable to: GI Physicians, Inc.)
There may be an additional charge if hemoccult or anoscopy are performed. You are responsible for timely payment of your account. **We reserve the right to reschedule or deny a future appointment on delinquent accounts.**

If your insurance card has any of the following: **PCP, Primary Physician, Managed Care, or HMO,** you may need an authorization from your family doctor before you can be seen. If you find the above letters or wording on your card, please call your family physician to be sure an authorization has been issued allowing you to be seen by one of our doctors.

SELF PAY: If you have no insurance, we require a $100.00 down payment on the date of your first visit, and a $50.00 payment on each subsequent visits. A payment plan will be established the date of your visit to ensure timely payments on the rest of your balance. Before a colonoscopy or EGD can be scheduled, we require a $100.00 down deposit. If both a colonoscopy and EGD are to be scheduled, we require $150.00 down deposit.

MEDICARE: We do accept assignment on Medicare. We file the Medicare claim; the payment comes to us; we take any necessary write-offs. Medicare patients are responsible for the 20% balance after Medicare has processed charges and any deductibles which have been applied. If you have supplement insurance we will file the claim if Medicare doesn't automatically.

MEDICAID: We do accept Medicaid patients; however, you must have your card with you at each visit. **PLEASE VERIFY WE ARE IN-NETWORK WITH THE NEW MANAGED CARE PLANS OR YOUR VISIT WILL NOT BE COVERED.**

ALL INSURANCE: We will be happy to file your office visit charges to your insurance; however, we ask that any **co-pay, deductibles, or uncovered services be paid at the time of visit.** All services which we provide at the hospitals are filed to your insurance company. Follow up visits are billed separately, they are not included in any other service provided.

WORKER'S COMPENSATION: We do accept Worker's Compensation patients but would like to advise that our diagnosis codes (gastroenterology) are many times not allowed by Workers' Compensation. If you feel your visits with us are due to a work-related problem, please check with the caseworker who is handling your claims to be sure your services will be covered.

Effective as of August 27, 2015

Any no show or cancellation without a 24 hour notice will be charged as the following: New Patient: $50.00. Follow up: $25.00. This cannot be billed to the insurance company and must be paid before scheduling a new appointment.