



specialists in gastroenterology advanced endoscopy center

Registration Form

Patient Information

Name: _____ Birth Gender: _____ Gender Identity: _____
Last First Middle Initial Nickname Male Female Male Female

Address: _____
Street City State Zip Code

Social Security Number: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____
Company Name Phone Number

Ethnicity: Non Hispanic or Latino Race: White Black/African American American Indian/Alaska Native
 Hispanic or Latino Asian Native Hawaiian/Pacific Islander Other
 Declined Declined

Preferred Language: English Spanish Other: _____

Marital Status: _____ Spouse's Name: _____ Spouse's DOB: _____

Spouse's Social Security Number _____ Spouse's Phone: _____

Spouse's Employer: _____ Spouse's Occupation: _____
Company Name Phone Number

In Case of Emergency Contact:

Name	Relation	Phone Number

Responsible Party (If Patient is Under 18)

Name: _____
Last First Middle Initial Nickname

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____
Company Name Phone Number

Physician Information

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Medical Insurance Information

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____ Relationship To Policy Holder: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____ Relationship To Policy Holder: _____

Signature Date of Birth Date

Legal Guardian Signature (If other than Patient) Legal Guardian (Print Name) Date

Notice of Privacy Practices

<p>Patient Health Information Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.</p> <p>How We Use Your Patient Health Information We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.</p> <p>Examples of Treatment, Payment, and Health Care Operations <u>Treatment:</u> We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. <u>Payment:</u> We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. <u>Health Care Operations:</u> We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.</p> <p>Special Uses We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.</p> <p>Other Uses and Disclosures We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: <u>Required by Law:</u> We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. <u>Research:</u> We may use or disclose information for approved medical research.</p>	<p><u>Public Health Activities:</u> As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities. <u>Health oversight:</u> We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities. <u>Judicial and administrative proceedings:</u> We may disclose information in response to an appropriate subpoena or court order. <u>Law enforcement purposes:</u> Subject to certain restrictions, we may disclose information required by law enforcement officials. <u>Deaths:</u> We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. <u>Serious threat to health or safety:</u> We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. <u>Military and Special Government Functions:</u> If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. <u>Workers Compensation:</u> We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.</p> <p>Individual Rights You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. <u>Request Restrictions:</u> You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.</p>	<p><u>Confidential Communications:</u> You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments. <u>Inspect and Obtain Copies:</u> In most cases, you have the right to look at or get a copy of your health information in electronic or paper form. There may be a small charge for the copies. <u>Amend Information:</u> If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information. <u>Accounting of Disclosures:</u> You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.</p> <p>Our Legal Duty We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.</p> <p>Changes in Privacy Practices We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person (s) listed below.</p> <p style="text-align: center;">Erin Patton---Administrator SIG 314-997-0554 Mellissa McCarthy-Administrator AEC 314-400-9999</p> <p>Release of Medical Information I authorize Specialists in Gastroenterology and or Advanced Endoscopy Center, LLC to use/or disclose certain medical and/or billing information to:</p> <p>Name: _____ Address: _____ _____ Phone#: _____ Relationship: _____</p> <p>Restrictions on the Disclosure of Medical Information (Must choose one)</p> <p><input type="checkbox"/> You can leave a detailed message (including billing, test results, medical information) <input type="checkbox"/> You may leave a message with no detailed information except a call back number and "Specialists in Gastroenterology" or "Advanced Endoscopy Center" identified <input type="checkbox"/> You may not leave a message</p>
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Signature: _____
Patient or Legal Guardian

Date: _____

Printed Name: _____

DOB: _____



Assignment of Benefits

Some insurance companies will not pay your bill if you do not select one of their participating doctors. It is the patient’s responsibility to determine if our doctor participates in your plan. Payment or co-payment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. If I default in payment I understand that I will be responsible for collection fees of 23% and/or legal fees.

Screening vs. Diagnostic Coverage

Insurance companies often provide screening benefits for routine screening colonoscopy. However, if during your screening procedure the physician removes a polyp or performs a biopsy, the procedure may be considered diagnostic and may not be covered as a screening exam. In this case, some insurance companies drop financial responsibility to the patient for all or part of the procedure cost. It is important for you to know if this applies to your routine screening benefits.

Insurance Information

- A. **Medicare:** The physicians accept Medicare assignments. Medicare claims will be filed by us, and Medicare will pay us directly. You will be responsible for the twenty percent (20%) co-payment in most cases, annual deductible, and possible non-covered charges.
- B. **Blue Cross Blue Shield/Anthem and Other Commercial Insurance:** Claims will be filed by us for your convenience. Most insurance Companies will send payment directly to us. In the event our payment is mailed to you, you are responsible for forwarding it to us for payment and any balance due on your account. You will also be responsible for any copayments, annual deductible amounts, and charges for non-covered services.
- C. **Medicaid.** Your Medicaid card must be presented at the time of service. We are not accepting new patients at this time except for direct Physician referrals.
- D. **HMO/PPO:** All claims will be processed directly from our office. **If a referral/authorization from your primary care doctor is required, you are responsible for obtaining and providing it to us at or before the time of your visit or you will be responsible for all charges.** You are also responsible for all co-payments, deductible amounts and non-covered services at the time of your visit. Co-payments should be paid at the time of your office visit unless prior arrangements have been made with the billing office.

Signature

Date

Printed Name

Date of birth

If you have any questions regarding your bill, please ask to speak with our Billing Department. We are more than willing to work a payment schedule with you if necessary on any outstanding charges. Please call our Billing Department at (314) 997-0554 option #6. THANK YOU FOR YOUR COOPERATION.



PATIENTS RESPONSIBILITIES

Dear Patient or Family Member:

This communication is to share some important information regarding answers to “Frequently Asked Questions” from patients or family members scheduled to receive care at Specialists In Gastroenterology (SIG) Advanced Endoscopy Center (AEC).

Please take a few moments to read below for information on several topics:

What you should understand about your insurance benefits:

- As a patient it is in your best interest to understand your insurance plan benefits and your responsibility for deductibles, co-insurance, co-payment amounts, referral’s and prior authorizations.
- If you have more than one insurance you are responsible for your own coordination of benefits (COB) your insurance carriers must know which is primary and secondary.
- If your insurance does not cover a service you may be liable for the entire amount. To find out more about your financial obligation, please call the customer service number of your insurance carrier located on the back of your insurance card.
- Policies and coverage determination may vary from year to year. Be sure to stay up to date on your coverage.
- Also, check with your insurance company to determine if the SIG physician you are seeing is listed as a participating provider. It is possible for one physician to be contracted and the others providers in the same office are not. Services provided by an out of network provider may lead to a larger financial responsibility for you.

What you need to do if your insurance requires a referral and/or a prior authorization:

- If your plan requires a referral, contact your primary care physician (PCP) prior to seeing a specialist.
- If your policy requires a referral and you do not have one, you will be responsible for full payment of your bill, OR you may be asked to reschedule your appointment.
- If more visits or tests are requested by the specialist, be certain to follow up with your PCP for an updated referral.

Prior authorizations on medication & compounded/specialty medications:

- Effective July 1st, 2014 insurance companies NO LONGER cover compound medications. If you are prescribed a compound medication by one of our providers it is the patient’s responsibility to pay out of pocket for these medications. SIG will not do prior authorizations on compound medications.
- If your medication requires a prior authorization please allow 1-6 weeks (business days only) for the prior authorization to be complete. Some medication may require additional time.

We request that you bring both your current insurance card AND a photo ID for each visit:

- Please bring the most current information to the appointment, and inform us of any changes. If you give incorrect insurance information that result in non-payment, you will be responsible for the entire the amount.
- Placement of your account with a collection agency or bankruptcy will result in termination of the patient/provider relationship. There will also be a 23% collection fee added to balances placed in collections.

Signature

Date

Printed Name

DOB

New Patient Form Name: _____ DOB: _____ Date: _____

Main Problem:

Date of onset or length of symptoms: _____ If it is pain, how long does it last: _____
Severity of this problem on a scale of 0 to 10 or state how severe it is to you: _____
Is it unchanged or worsening? _____
If it is pain, where is it located? _____ If moves where does it go? _____
If it is pain, what words would you use to describe it? _____
For this problem, when does it usually occur (i.e., after meals, with stress, est.)? _____
What makes it worse? _____
What makes it better? _____
What other symptoms occur at the same time? _____

Second Problem (if applicable):

Date of onset or length of symptoms: _____ If it is pain, how long does it last: _____
Severity of this problem on a scale of 0 to 10 or state how severe it is to you: _____
Is it unchanged or worsening? _____
If it is pain, where is it located? _____ If moves where does it go? _____
If it is pain, what words would you use to describe it? _____
For this problem, when does it usually occur (i.e., after meals, with stress, est.)? _____
What makes it worse? _____
What makes it better? _____
What other symptoms occur at the same time? _____

Other important information:

Colonoscopy and Upper Endoscopy: If performed, give result and year; obtain records if possible.

Radiology study (CAT scan, upper GI, etc): if applicable, result and year; obtain records if possible.

Lab studies (CBC, chemistry, liver profile, etc): obtain records of recent or important results.

Immunizations: State "Yes" if up-to-date, "No" if never had or not up-to-date, of "?" if unsure:
Hepatitis A _____; Hepatitis B _____; HPV _____; Tetanus _____; Influenza in the last year _____;
Pneumovax _____; Shingles _____; TB testing (date of test) _____

List of surgeries:

Gastrointestinal Family History: colon cancer/polyps, celiac disease, colitis, Crohn's disease, gallbladder stones/surgery, irritable bowel syndrome, liver disease, osteoporosis, ulcers, ulcerative colitis, pancreatitis
Diagnosis/Relationship (example: Colon cancer/Father): please include parents, siblings and grandparents

Name: _____ DOB: _____ Date: _____

Social History: Check the line next to the word if this applies to you and provide frequency (daily, weekly, ...) Tobacco use _____ Alcohol use: _____ Caffeine use: _____ Past IV drug use (risk of hepatitis C): _____ Frequency: _____ Frequency: _____ Frequency: _____

Employment/Occupation:

Toxin exposures at work or home:

Review of Symptoms: If there is a regularly occurring problem, then check the line next to the problem.

General: Poor appetite _____; Fatigue _____; Fever _____; Weight loss _____; Weight gain _____
ENT: Dry eyes _____; Eye pain or Dry eyes _____; Hoarseness _____; Mouth sores _____
Lungs: Cough _____; Wheezing _____
Heart: Chest pain _____; Irregular heart beats _____
Vascular: Leg swelling _____; Raynaud’s disorder (whitening of fingers in cold) _____
Gastrointestinal: Bleeding _____; Difficulty swallowing _____; Leakage of stool _____
Urinary: Red or cloudy urine _____; Flank pain _____; Frequent urination _____
Reproduction: Infertility _____; Pain with sex _____; No periods _____; Heavy periods; _____
Endocrine: Cold intolerance ____; Heat intolerance ____; Increased skin pigment __; stretch marks ____
Neurological/Psychological: Dizziness _____; Severe headaches _____; Seizures _____
Vertigo _____; Restless legs (compelling urge to move legs) _____; Anxious _____; Depressed _____
Skin: Abnormal fingernails _____; Rash (including painful nodules, eczema, psoriasis) _____: Lesion suspicious for cancer _____; Rosacea (flushing, redness, bumps, skin thickening) ____
Muscle/bone: Arthritis/joint pain _____; Sore muscles _____; Weakness _____
Blood disorders: Easy bleeding _____; Easy bruising _____
Immune: Hay fever and/or seasonal allergies _____; Hives _____; Throat/Extremity swellings _____

More details for above problems, if needed

Allergies (medications/food):

Medical problems and medications: example: [diabetes] [Metformin] [500 mg] [2] or [diabetes] [none]

Medical Problem	Medication***	dose	Pills per day	<u>**or please bring in list**</u>
				Additional Medications/Supplements

Pharmacy telephone number: _____