Registration Form

Patient Information

Birth Gender: ☐Male ☐Female Gender Identity: ☐Male ☐Female

Name: ____
Last First Middle Initial Nickname

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 ☐Hispanic or Latino ☐Declined

Race: ☐White ☐Black/African American ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Other ☐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

SIG
specialists in gastroenterology

AEC
advanced endoscopy center

Notice of Privacy Practices

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.

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.

Examples of Treatment, Payment, and Health Care Operations
Treatment: 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.
Payment: 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.
Health Care Operations: 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.

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.

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:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: 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.
Military and Special Government Functions: 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.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-elated 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.

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.
Request Restrictions: 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.
Confidential Communications: 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. *Inspect and Obtain Copies:* 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.
Amend Information: 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.
Accounting of Disclosures: 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.

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.

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.

Erin Patton---Administrator SIG 314-997-0554

Mellissa McCarthy-Administrator AEC 314-400-9999

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:

Name:________________________________

Address:________________________________

____

Phone#:________________________________

Relationship:____________________________

Restrictions on the Disclosure of Medical Information (Must choose one)

____You can leave a detailed message (including billing, test results, medical information)
____You may leave a message with no detailed information except a call back number and “Specialists in Gastroenterology” or “Advanced Endoscopy Center” identified
____ You may not leave a message

Signature:____ Date:____________________________
Patient or Legal Guardian

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

specialists in gastroenterology advanced endoscopy center

Patient Medication Information

Patient Name:____ **Patient DOB:**________________________

Primary Pharmacy:________________________________ **Pharmacy Phone:** (_____)__________________

Medication Allergies:

Name	Reaction
(example: Sulfa)	(rash)

Medications: (Please Print all Medications, Supplements and Over the Counter Medications)

Name	Dose/mg	How Many Times a Day do You Take This Medication?	Why do you take this Medication?
(example: Aleve)	(200mg)	(as needed)	(headaches)
(example: Coumadin)	(5mg)	(once daily)	(blood thinner)

Problems List

Name: ________________________________ Birth Date:___________________ Date:_______________

Medical Conditions:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____

Surgeries and Dates:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____

Medical History (Personal/Family)

	Patient's History	Family (Parent, Sibling, Child)
Colon Polyps:		
Colon Cancer:		
Colitis/Crohn's Disease		
Irritable Bowel:		
Stomach Ulcer:		
Gallstones:		
Pancreas Disease:		
Diabetes		
Breast Cancer:		
Uterine Cancer:		

Olde Cabin Anesthesia, LLC

Providing Professional Anesthesia Services for patients of Advanced Endoscopy Center

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to Olde Cabin Anesthesia, LLC **(OCA)** all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of Practice charges for this admission or other amounts as may be provided by an agreement between OCA and my insurance company. I authorize and direct the insurance company to pay all such benefits to OCA. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and OCA.

Authorization to Release Claims Information: I hereby authorize OCA its employees, contractors, and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my, the patient's, medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare) or any private reimbursement which may have a bearing on benefits payable by or on behalf of any such person. I hereby authorize OCA its employees and agents to act on my behalf in completing claims including any appeal process.

Precertification & Financial Responsibility: I understand that my insurer may require compliance with utilization review (UR) program to ensure that plan benefits are justified. I understand that it is the insurer's UR program's responsibility to review proposed elective admissions and anticipated courses of treatment. I understand that if the UR program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that OCA is willing to provide professional anesthesia services as requested by my attending physician. I also understand that I may be financially responsible for all related charges incurred as a result of this admission should the UR review program refuse to certify that the admission or a specific service was appropriate or should the certification effort occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company, UR program and personal physician without delay and in advance of my admission.

Authorized Representation: I do hereby name OCA to act as my authorized representative in requesting a complaint, an appeal, and documents from my health insurance provider regarding services rendered by OCA. I understand and agree that 1) this authorization is voluntary: 2) my health information may contain information created by other persons or entities including healthcare providers and may contain medical, pharmacy, dental, vision, mental, health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care information; 3) I may not be denied treatment, payment for healthcare services, or enrollment or eligibility for healthcare benefits if I do not sign this form; 4) this authorization will expire one year from the date I sign this form. I may revoke this authorization at any time by notifying OCA and/or health insurance provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

____

Signature of Patient/Authorized Guardian Signature **Date**

PATIENT NOTICE REGARDING ANESTHESIA SERVICES

Anesthesia services are provided at Advanced Endoscopy Center by OCA. OCA contracts and employs certified registered nurse anesthetists as part of the anesthesia care team.

Anesthesia services will be billed separately from the services of Advanced Endoscopy Center.

For billing questions or concerns, please call: 314-818-1385 or 1-888-337-3509

In the event that OCA is not a participating provider with your insurance plan, OCA will work with your insurance carrier through various appeal efforts in order to minimize any penalties or costs that your insurance says that you owe. We are often able to negotiate with your insurer to reduce your out-of-pocket expenses that may result from OCA's out-of-network status, but we cannot guarantee a result. You will also be required to pay the deductible and/or co-pay amounts determined by your policy/plan.