SGC Specialty Gastro Center

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Board Certified in Gastroenterology and Hepatology

PATIENT INFORMATION

Date: ☐New Patient ☐Follow Up

Patient:

Last First MI Preferred Title

☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

Patient Date of Birth: Patient SSN:

Address:

Address Line 1

Home:

Address Line 2

Cell:

Other:

City ST ZIP Code

Fax:

E-Mail:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

Tel:

Name Relationship

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

Address Line 1

Work: X

Direct:

Address Line 2

Other:

Pager:

City ST ZIP Code

Fax:

E-Mail:

INSURANCE INFORMATION

Insurance: ☐Medicaid ☐Medicare ☐HMO ☐PPO ☐Self Pay ☐Other

Primary Insurance Carrier:

Policy Number: Date of Birth:

Subscriber Name: Subscriber SSN:

Subscriber Employer:

Insurance: ☐Medicaid ☐Medicare ☐HMO ☐PPO ☐Self Pay ☐Other

Secondary Insurance Carrier:

Policy Number: Date of Birth:

Subscriber Name: Subscriber SSN:

Subscriber Employer:

PHARMACY INFORMATION

Pharmacy Name: Pharmacy #: City/State

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical or medical benefits. I am responsible to pay no-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in course of my treatment necessary to process insurance claims,

Signature:____ Date:____________________

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PRIMARY CARE PHYSICIAN

Primary Care Physician : ______________________ Telephone: ______________________

First Last

Clinic/Facility: ______________________

Address: ______________________

____

City ST ZIP Code

PAST MEDICAL HISTORY

All Patients: Do you have, or have you ever had any of the following? (Check all that apply): ☐None

☐Anemia	☐ COPD	☐ High Blood Pressure	☐ Phlebitis
☐Arthritis	☐ Coronary Artery Disease	☐ High Cholesterols	☐Pneumonia
☐ Asthma	☐ Crohn's Disease	☐ HIV or AIDS	☐Prostate Enlargement
☐ Atrial Fibrillation	☐ Depression	☐ Irregular Heart Beat	☐Psoriasis
☐ Barrett's Esophagus	☐ Diabetes	☐ Irritable Bowel Syndrome	☐Rheumatic Fever
☐ Bleeding Disorder	☐ Diverticulitis	☐ Kidney Disease/ Failure	☐Sciatica
☐ Blood Transfusion	☐ Fatty Liver	☐ Liver Disease	☐Seizures
☐ Cancer	☐ Gallbladder Disease	☐ Neurologic Disorders	☐Sleep Apnea
☐ Chronic Anxiety	☐ Gastritis	☐ Osteoporosis	☐Stroke
☐ Chronic Sinusitis	☐ GERD (Reflux)	☐ Ovarian Cyst	☐TB (Tuberculosis)
☐ Cirrhosis	☐ GI Bleeding	☐ Pancreatitis	☐Thyroid Disorders
☐ Colon Cancer	☐ Heart Attack	☐ Parkinson's Disease	☐Ulcerative Colitis
☐ Colon Polyps	☐ Heart Murmur	☐ Peptic Ulcer	☐Vascular Heart Disease
☐ Congestive Heart Failure	☐ Hepatitis	☐Other – please list: ______________	
☐ Constipation	☐ Hiatal Hernia	☐Other – please list: ______________	

Female Patients: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

SURGERIES/ PROCEDURES

All Patients: Do you have, or have you ever had any of the following? (Check all that apply): ☐None

☐Appendectomy	☐EGD	☐Kidney Surgery	☐Small Bowel Resection
☐Barium Enema	☐ERCP	☐Liver Biopsy	☐Stomach Surgery
☐Breast Surgery	☐Gallbladder Surgery	☐Obesity Surgery	☐Thyroid Surgery
☐Capsule Endoscopy	☐Heart Bypass	☐Ovarian Surgery	☐Tonsillectomy
☐Cholecystectomy	☐Heart Valve Replacement	☐Pacemaker Placement	☐Tubal Ligation
☐Colon Surgery	☐Hemorrhoid Surgery	☐ Prostate (TURP)	☐Ulcer Surgery
☐Colonoscopy	☐Hiatal Hernia Repair	☐Radiation Therapy	☐Upper GI Series X-Ray
☐Colostomy	☐Hysterectomy	☐Sigmoldoscopy	☐Uterine Surgery
☐C-Section	☐Joint Replacement	☐ Other – please list: ______________	
		☐Other – please list: ______________	

SOCIAL HISTORY

Marital Status:	☐Married	☐Single	☐ Divorced	☐ Widowed
Occupation: ______________		☐Unemployed	☐Retired	
Smoking History:	☐Never	☐Yes; _____ Pack a day for ____years; Quit_____(how long)		
Other Tobacco Use:	☐No	☐Yes; Details: ______________		
Alcohol Use:	☐No	☐Yes; amount per day ______________		
Drug Use:	☐No	☐Yes; specify drugs and amounts ______________		
Exercise Habits:	☐No	☐Yes; how much and how often ______________		
Recent Travel Outside US:	☐No	☐Yes; Where ______________		
Caffeine Use	☐No	☐Yes; How much and how often ______________		
Voluntary Tattoo	☐No	☐Yes; When ______________		

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FAMILY HISTORY

	Father	Mother	Brother/ Sister	Other
Colon Polyps	☐	☐	☐	
Colon Cancer	☐	☐	☐	
Gastric Ulcer Disease	☐	☐	☐	
Liver Disease	☐	☐	☐	
Pancreas Disease	☐	☐	☐	
Crohn's Disease	☐	☐	☐	
Ulcerative Colitis	☐	☐	☐	
Stomach Cancer	☐	☐	☐	
Diabetes Mellitus	☐	☐	☐	
Heart Attack	☐	☐	☐	
Breast Cancer	☐	☐	☐	
Other Cancer	☐	☐	☐	
Other: ________________	☐	☐	☐	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ Aspirin ☐ Codeine ☐ Lactose Intolerance ☐ Sleeping Pills ☐ None
☐ Anesthetic – Local ☐ Dairy ☐ Metal Sensitivity ☐ Sulfa Drugs
☐ Barbiturates ☐ Latex ☐ Nitrous Oxide Sedation ☐ Penicillin/Other Antibiotics
☐ Other – please list: ....

MEDICATION INFORMATION

All Patients: Are you currently taking any of the following? (Check all that apply): ☐ None

☐ Antibiotics/Sulfa Drugs ☐ Antihistamines/Allergy ☐ Daily Aspirin ☐ Blood pressure Medications
☐ Blood thinners ☐ Cancer/Chemo Medications ☐ Cortisone/Steroids ☐ Heart Medication/Digitalis
☐ Insulin ☐ Nitroglycerin ☐ Oral Contraceptives ☐ Osteoporosis Medications
☐ Other Diabetic Medications ☐ Recreational Drugs ☐ Thyroid Medications ☐ Tranquilizers
☐ Other (please list below)

Drug Name	Dosage	Reason Prescribed

ETHNICITY / RACE / LANGUAGE

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Ethnicity Not Known By Patient
☐ Declined to Specific Ethnicity

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Preferred Language

☐ English
☐ Spanish
☐ Other ________________

Additional Language

____

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REVIEW OF SYSTEMS

CHECK ALL THAT APPLY AT THE PRESENT TIME:

☐ NONE

GENERAL
- ☐ Chills
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Night Sweats
- ☐ Weight Gain
  Amount? ______
- ☐ Weight Loss
  Amount? ______
- ☐ Feeling Tired or Poorly

EYES
- ☐ Worsening Vision
- ☐ Blurred Vision
- ☐ Vision Distortion
- ☐ Eye Pain

OTOLARYRIGEAL SYMPTOMS
- ☐ Earache
- ☐ Nasal Discharge
- ☐ Mouth Sores
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Throat Pain
- ☐ Facial Pain
- ☐ Sinus Pain

CARDIOVASCULAR
- ☐ Chest Pain/Discomfort
- ☐ Fast Heart Rate
- ☐ Swelling of Legs
- ☐ Varicose Veins
- ☐ Other – please list: ______
- ☐ Other – please list: ______

RESPIRATORY
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Swelling
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black Stools
- ☐ Red blood in Bowel Movement
- ☐ Change in Bowel Movement Frequency
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Fatty Food Intolerance
- ☐ Full After Eating Small Meal
- ☐ Bloating/Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Yellow Skin or Eyes
- ☐ Gallbladder Disease
- ☐ Nausea
- ☐ Pain with Swallowing
- ☐ Decrease in Appetite
- ☐ Rectal Bleeding
- ☐ Rectal Pain
- ☐ Regurgitation of Food
- ☐ Incontinence of Stool
- ☐ Vomiting
- ☐ Vomiting Blood

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Swollen Joints
- ☐ Low Back Pain
- ☐ Muscle Pain

SKIN SYMPTOMS
- ☐ Pruritis (Itching)
- ☐ Skin Lesions
- ☐ Rashes

NEUROLOGIC
- ☐ Numbness or Tingling
- ☐ Dizziness/lightheadedness
- ☐ Vertigo
- ☐ Headaches
- ☐ Weakness in Arms or Legs
- ☐ Blurred Vision
- ☐ Memory Lapses or Loss

PSYCHLATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Loss of Sleep

- ☐ Other – please list: ______
- ☐ Other – please list: ______

ENDOCRINE
- ☐ Heat or Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Hot Flashes

HEMATOLOGIC / LYMPHATIC
- ☐ Easy Bruising Tendency
- ☐ Swollen Glands
- ☐ Nosebleeds

URINARY
- ☐ Pain of Difficulty with Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence of Urine

GENITOREPRODUCTIVE FEMALE
- ☐ Vaginal Discharge
- ☐ Heavy Periods

Date of Last Period ______

GENITOREPRODUCTIVE MALE
- ☐ Discharge from Penis
- ☐ Testicular Pain
- ☐ Testicular Lump

Notice of Privacy Practice

This notice apply to Specialty Gastro Center, LLC and all of its subsidiaries. This Notice describes how medical information about medical information about you may be used and disclosed and you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request. 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 some 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 treatments 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 or may be participating in your treatment, to pharmacist or pharmacy personnel who are filling your prescription and to family members, significant other, health aid(s) or surrogates who are helping your care. *Payment*: We will use and disclose your health information for payment purpose. 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 via phone, fax, email, postcard or letter. 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 or/and research. We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries or event.
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 respond 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 death to coroners, medical examiners, funeral directors and organ donation agencies.
Serious Threat to Health of Safety: we may have 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-related injuries or illness. In many other situations we may ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign and an authorization to disclose information, you can later revoke that authorization to stop any future used and disclosure.

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 from certain usages 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.
- *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 Copy*: you have the right to inspect and copy the protected health information that we maintain about you in out designated records set for as long as we maintain that information. This designated record set includes your medical billing records, as well as any other records we use for making decision about you. Any psychotherapy notes that may have been included in your records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of coping, mailing or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our contact person. You may mail in your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information stored off site, we are allowed up to 60 days to respond but must inform you of this delay.
Amend Information: if you believe that information in your record is incorrect or important information is missing, you have the right to request that we correct the existing information or add missing information.
Accounting Discourse: you may request a list of instances where we have disclosed health information about you for reason 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 above 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 Practice: we may change our policies at anytime. Before we made a significant change in our policy 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 anytime. For more information about our privacy practices, contact the office manager at this location.

Complains
If you are concern that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the office manager at the location of your specialty gastro care physician. You may also send a written complaint to U.S. Department of Health and Human Services. You will not be penalized in any way for filling a complaint.

Effective Date: December 1, 2006
I, ________________________________ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signature: ________________________________ Date: ____________________

Relation to patient*: ________________________________

*(please provide legal validation of right to accept on behave of the patient)

Financial Policy

Thank you for choosing **Specialty Gastro Center** as your health care provider. We are committed to providing you the best possible medical care. We would like to keep you informed of our current office and financial policies. We require you to read and sign this agreement. We will place a signed copy in your chart, and you may keep the original for future reference.

Insurance: As a courtesy, our office will bill your insurance for the services you receive. We cannot bill your insurance company unless you give us your correct insurance information. Please understand that your medical insurance is a contract between you and your insurance company. We are not a party to that contract, and your bill is ultimately your responsibility whether your insurance company pays or not. We can often help with providing information to help get your claim paid, but if your insurance company has not paid your account in full within 45 business days, it will then become your responsibility to pay the balance.

Co-payments, deductibles and fees: All co-payments, insurance deductibles and fees for services not covered by your insurance policy are due at the time service is rendered. The co-pay cannot be waived, as it is a requirement placed on you by your insurance company.

No insurance: Payment is due at the time of service. If you are unable to pay your balance in full, you must make prior arrangements with our Office Manager.

Payment: We accept cash, personal checks, VISA, Master Card, Discover Card and American Express.

Returned checks: A $30.00 charge will be added to your account for any check returned by your bank for any reason. This will be in addition to any charges applied by your bank.

Missed appointments: If you are unable to keep your scheduled appointment, please call our office at least 24 hours in advance to cancel or to reschedule. This will allow us to provide that time slot to another patient.

New patients who miss an appointment may reschedule, but after two missed appointments, the referring doctor's office must call to reschedule. Established patients who miss an appointment may reschedule, but missing three appointments in a 12 month period may result in dismissal from our practice. Likewise, not showing up for an endoscopy appointment may also result in being dismissed from our practice.

I have read the Specialty Gastro Center Financial Policy in full, and I understand and agree to this policy. I acknowledge full financial responsibility for services rendered by Specialty Gastro Center. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-payments. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. I understand that payment of co-payments is expected at the time of service, as well as any prior balance that I owe. I understand the policy regarding missed appointments. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to Specialty Gastro Center for any medical or endoscopic services furnished.

________________________	______________________________	________________
Printed Name	Signature of Patient	Date Signed

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the doctor and staff at the next appointment without fail.

I hereby authorize payment directly to Specialty Gastro Center, LLC of the medical benefits otherwise payable to me.

I hereby authorize Specialty Gastro Center, LLC to release any information concerning my health or medical care, advice, treatment, or supplies provided. This information is to be used in administering medical claims and/or discussing treatment options with other medical professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:____ Date:_________________________________

POWER OF ATTORNEY FOR HEALTH CARE

1. Name: ____ Phone Number:___________________________
2. Name: ____ Phone Number:___________________________
3. Name: ____ Phone Number:___________________________
4. Name: ____ Phone Number:___________________________
5. Name: ____ Phone Number:___________________________
6. Name: ____ Phone Number:___________________________
7. Name: ____ Phone Number:___________________________
8. Name: ____ Phone Number:___________________________
9. Name: ____ Phone Number:___________________________
10. Name: ____ Phone Number:___________________________

Signature:____ Date:_________________________________

Authorization for Release of Protected Health Information

Patient Name: ____
Last Initial First

Date of Birth: ________________ Address: ____

To: ____

I have been a patient at the Practice or I am the patient's authorized representative. I understand that the facility has legally protected health information about me or the person I represent. I understand that signing or not signing this form will not affect treatment I receive in any way.

I hereby authorize release my records to: Specialty Gastro Center, LLC
(Name of individual, Facility, Agency, School, or Entity to Receive Health Information)

____ Hospital/Doctor documents (H&P, op notes, discharge summary, etc)
____ Lab Results ___________________________________
____ Radiology Results (x-ray, CT, MRI, etc)
____ Medication list
____ The above information and/or the entire Medical Records which includes HIV-Related information.
____The above information and / or the entire Medical Records including mental health, drug or alcohol treatment
____ Entire Medical Record EXCLUDING HIV-Related, mental health, drug, or alcohol treatment
____Other (specify): ____
From (date): ___________________________________to (date): _______________________

I understand that this authorization is subject to revocation at any time, except to the extent that Specialty Gastro Center has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing delivered to the Privacy Officer. I understand that recipients may redisclose information which I have authorized them to receive.

_________________________________ ___________ ___________________________________ ________
Patient or Representative Signature Date Witness Date
(If representative, give relationship and authority to act) (When required by policy or signing by mark)

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Fax: 954-428-2904

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Fax: 954-757-4003