

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 _____

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 The Notice 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

IMPORTANT INFORMATION ABOUT GRACHIE

What is GRACHIE (Pronounced 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 providers 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

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

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

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

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

Name _____

Date of Birth _____

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

| |
|-------|
| _____ |
| _____ |
| _____ |
| _____ |

Name _____

Date of Birth _____

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

| | Mother | Father | Sister | Brother | Son | Daughter | Age at Diagnosis |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------|
| Barrett's Esophagus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Colon Polyps | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crohn's Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ulcerative Colitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hyperlipidemia/ High Cholesterol (HLD) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease/ Coronary Artery Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Cancers

| | | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------|
| <input type="checkbox"/> Colon | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Esophagus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Other (Specify) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| None of the Above | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

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 _____