PATIENT HISTORY FORM

Today's Date:_____/_____/_____

Patient Name:_____ DOB:_____/_____/_____

Reason for today's visit:_____

MEDICAL HISTORY (Please circle any that apply)			
Anemia	Depression	Hypertension	Seizures
Anxiety	Diabetes	IBD	Substance abuse
Arthritis	Diverticulitis	IBS	Thyroid disease
Asthma	Diverticulosis	Kidney Disease	Tuberculosis
Blood transfusion	Emphysema	Liver Disease	Ulcers
Cataracts	GERD	Meningitis	
CHF	Glaucoma	Myocardial Infarction	
Colon Polyps	Hepatitis C	Nerve/muscle disease	
COPD	HIV/AIDS	Osteoporosis	

WOMENS HEALTH HISTORY		
Having Periods	yes	no
Date of Last Cycle:____/_____/____		
Hysterectomy	yes	no
Removal of Ovaries	yes	no
Menopause	yes	no
C-Section	yes	no
Tubal Ligation	yes	no
Currently Pregnant	yes	no
Breast Surgery	yes	no

SURGICAL HISTORY (Please circle any that apply)			
Appendectomy	Cosmetic Surgery	Joint Replacement	Valve Replacement
Brain Surgery	Fracture Surgery	Nissen Fundoplication	Vasectomy
Breast Surgery	Gastric	Prostate Surgery	Other:_____
CABG	Gastric Bypass	Small Intestine Surgery	Date of Last:
Cholecystectomy	Heller Myotomy	Spine Surgery	Colonoscopy___/____/_____
Colon Surgery	Hernia Surgery	Tonsillectomy	Upper Endoscopy___/___/____

FAMILY HISTORY WORKSHEET

____adopted _____family history unknown (please check any that apply)

MGM/MGF (maternal grandmother/father)

PGM/PGF (paternal grandmother/father)

	Mother	Father	Sister	Brother	Son	Daughter	MGM	MGF	PGM	PGF
Arthritis										
Asthma										
Crohn's Disease										
Colon Cancer										
Colon Polyps										
Uterine Cancer										
Ovarian Cancer										
Breast Cancer										
Esophageal Cancer										
Gastric Cancer										
Pancreatic Cancer										
Other Cancer:_____										
Celiac Disease										
Depression										
Heart Disease										
Diabetes										
Drug Abuse										
Hyperlipidemia										
Kidney disease										
Mental Illness										
Migraines										
Osteoporosis										
Stroke										
Thyroid Disease										
Ulcers										
Ulcerative Colitis										
Deceased										

Allergies:_____no_____yes
If yes please list:_____

Soy allergy_____no_____yes
Peanut allergy _____no_____yes
Latex allergy_____no_____yes
IV contrast allergy_____no_____yes

TOBACCO USE:

Smoking Status:		Cigarettes	
Current Everyday		Cigar	
Current Some Day		Pipe	
Former	Date quit	/ /	
Never Assessed			
Never Smoker			
Passive Smoker			
Unknown			

Smokeless Tobacco:	
Snuff	Chew
Current User	
Former User	
Never	
Unknown	

FAMILY:	
Married	
Single	
Divorced	

ALCOHOL USE:

Yes		
No		
Drinks Per Week		

ILLEGAL DRUG USE:	
NO	
YES	
If yes:	

Use /week	Type

SEXUAL ACTIVITY:	
no	
not currently	
yes	
Partner	
Male	
Female	

Birth Control Protection:_____

CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

Preferred Pharmacy:_____
Address:_____
Telephone # ( )-_____-_____

Patient Name:_____ **Date of Birth:**_____

To better assist us with your visit today
Please let us know if you have had the following symptoms

Activity change	yes	no	**Chest pain**	yes	no	**Arthralgias**	yes	no
Appetite change	yes	no	**Leg swelling**	yes	no	**Back pain**	yes	no
Chills	yes	no	**Palpitations**	yes	no	**Cold intolerance**	yes	no
Diaphoresis	yes	no				**Gait problem**	yes	no
Fatigue	yes	no	**Abdominal bloating**	yes	no	**Heat intolerance**	yes	no
Fever	yes	no	**Abdominal pain**	yes	no	**Joint pain**	yes	no
Unexpected weight change	yes	no	**Anal bleeding**	yes	no	**Joint stiffness**	yes	no
			Blood in stool	yes	no	**Joint swelling**	yes	no
Facial swelling	yes	no	**Black stool**	yes	no	**Muscle cramps**	yes	no
Neck pain	yes	no	**Constipation**	yes	no	**Myalgias**	yes	no
Neck stiffness	yes	no	**Nausea**	yes	no			
Ear discharge	yes	no	**Diarrhea**	yes	no	**Skin color change**	yes	no
Hearing loss	yes	no	**Rectal pain**	yes	no	**Pallor**	yes	no
Ear pain	yes	no	**Vomiting**	yes	no	**Rash**	yes	no
Tinnitus	yes	no	**Vomiting blood**	yes	no	**Wound**	yes	no
Nosebleeds	yes	no	**Abnormal menstrual period**	yes	no			
Congestion	yes	no	**Abnormal vaginal bleeding**	yes	no	**Dizziness**	yes	no
Rhinorrhea	yes	no	**Blood in urine**	yes	no	**Facial asymmetry**	yes	no
Sneezing	yes	no	**Difficulty urinating**	yes	no	**Headaches**	yes	no
Sinus pressure	yes	no	**Dysuria**	yes	no	**Light-headedness**	yes	no
Dental problem	yes	no	**Enuresis**	yes	no	**Numbness**	yes	no
Drooling	yes	no	**Flank pain**	yes	no	**Seizures**	yes	no
Mouth sores	yes	no	**Frequency**	yes	no	**Speech difficulty**	yes	no
Sore throat	yes	no	**Genital sore**	yes	no	**Syncope**	yes	no
Trouble swallowing	yes	no	**Hematuria**	yes	no	**Tremors**	yes	no
Voice change	yes	no	**Pain with urination**	yes	no	**Weakness**	yes	no
			Pelvic pain	yes	no			
Eye discharge	yes	no	**Penile discharge**	yes	no	**Adenopathy**	yes	no
Eye itching	yes	no	**Penile pain**	yes	no	**Bruises/bleeds easily**	yes	no
Eye pain	yes	no	**Penile swelling**	yes	no			
Eye redness	yes	no	**Scrotal swelling**	yes	no	**Agitation**	yes	no
Photophobia	yes	no	**Testicular pain**	yes	no	**Behavior problem**	yes	no
Visual disturbance	yes	no	**Urgency**	yes	no	**Confusion**	yes	no
			Urine decreased	yes	no	**Decreased concentration**	yes	no
Apnea	yes	no	**Urinary incontinence**	yes	no	**Depression**	yes	no
Chest tightness	yes	no	**Vaginal discharge**	yes	no	**Dysphoric mood**	yes	no
Choking	yes	no	**Vaginal pain**	yes	no	**Hallucinations**	yes	no
Cough	yes	no				**Nervous/anxious**	yes	no
Shortness of breath	yes	no				**Self injury**	yes	no
Stridor	yes	no				**Sleep disturbance**	yes	no
Wheezing	yes	no				**Suicidal ideas**	yes	no

Digestive Healthcare of Georgia, P.C.

Disclosures to Family Members Policy

Patient Name:_____MRN_____

Digestive Healthcare of Georgia has adopted the Disclosures to Family Members Policy to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the HITECH Act, the Department of Health and Human Services ("DHHS") security and privacy regulations, and the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") accreditation standards, as well as it being our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.

To ensure Digestive Healthcare of Georgia meets the guidelines of the Disclosures to Family Members Policy, we would like to reassure that the family members and/or close personal friends with whom the patient would like to share PHI (Protected Health Information) is relevant to that individual's involvement with the patient's care. Anyone whom the patient allows to be a part of their PHI will also be able to hear the physicians results after the patient's procedure.

Please select one of the following:

☐ I **DO NOT** object to disclosing my health information

☐ I **DO** object to disclosing my health information

_____ Date_____

Patient Signature

Digestive Healthcare of Georgia , P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

DOB:_____/_____/_____ Social Security #:_____/_____/_____

I understand that, as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment. I hereby give my consent for Digestive Healthcare of Georgia, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I have been given the opportunity to read the "Notice of Privacy Practices" which provides a more complete description of such issues and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Digestive Healthcare of Georgia reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Digestive Healthcare of Georgia Privacy Officer at 95 Collier Rd., Suite 4075, Atlanta GA 30309.*

I reserve the right to restrict information, medical or financial, that Digestive Healthcare of Georgia is authorized to release and/or designate specific individual/entities authorized and/or discuss the information regarding my care. If I choose to restrict the release of information and/or the individuals/entities that may receive this information from Digestive Healthcare of Georgia, I may do so by completing the "Authorization to Restrict/Release Personal Health Information" form that will be placed in my permanent chart.

With this consent, Digestive Healthcare of Georgia may call my home or other alternative location as specified by me, and leave a message in person or on voice mail regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance inquiries/information ,and/or calls pertaining to my clinical care, including test results (laboratory, X-rays, etc).

I may revoke this consent in writing to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Digestive Healthcare of Georgia may decline to provide treatment to me. By signing this form, I am consenting Digestive Healthcare of Georgia's use and disclosure of my PHI to carry out TPO as permitted by the Health Information Portability and Accountability Act (HIPAA)

I understand that information contained in my medical chart serves as:

- a basis for planning my care and treatment
- a means of communication among the many healthcare professionals who contribute to my care.
- a source of information for applying my diagnosis and surgical information to my bill.
- a means by which a third party can verify that services billed were actually provided.
- a tool of routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

_____ _____/_____/_____

Signature of Patient, Guardian or Legal Representative Date

_____ _____/_____/_____

Witness Signature Date

Digestive Healthcare of Georgia
Patient Financial Responsibilities

(Please bring this signed form with you to your appointment)

Digestive Healthcare of Georgia welcomes you to its family of physicians and healthcare providers. We are pleased you have chosen us to care for you and we commit to enhance the value and quality of your care. This policy statement is intended to answer questions you may have regarding payment for services rendered at our facilities or in the hospital setting by members of the group. Your questions and comments are welcomed.

While we hope to maintain a longstanding relationship with you, we must ensure all patients follow our policies. We require all our patients to read and sign this document and we will maintain this in our files. Failure to adhere to these financial policies can result in dismissal from the practice.

Payment For Services

For your convenience, we accept cash, VISA, MasterCard, and AMEX, debit cards, traveler's checks, money orders and personal checks. Starter checks and postdated checks are not accepted. A valid picture ID is required on all checks. **If co-payments, coinsurances and/or deductibles are required by your insurance plan, they are due when services are rendered.**

Cancellation/No Show Policy

To ensure that all our patients have access to our physicians, we have established the following fees for late cancellations and no shows. Office visits cancelled less than 24 hours of the appointment may be subject to a charge of $50.00. Procedures cancelled less than 72 hours of the appointment may be subject to a charge of $100.00. These charges will be billed to the patient and not their insurance carrier.

Self Pay Patients

The group welcomes self-paying patients when no insurance coverage is available for our services. Patients who have no insurance are asked to pay in full at the time of service. If for any reason you may be unable to pay in full at the time of service, speak with the billing manager in advance of the visit to determine if reasonable payment arrangements can be established with the group. New patients without insurance are required to pay a $150 retainer when checking in. This will be applied to your visit and you will be asked for the balance or if the visit is less than $150, you will be refunded the difference during checkout.

Filling out Forms

For your convenience, our physicians will fill out forms for our patients. The fee for this service is **$30.00**. This fee must be paid when the form is mailed or dropped off at the practice. Patients are not required to pay a fee for State disability or Workers Compensation forms.

Insurance Coverage

Your Physician's Participation With Your Insurance Plan

Our group accepts most major insurance plans. Prior to your initial visit, please contact your insurance carrier to confirm that the physician you'll be seeing participates in your plan. If a procedure is necessary and you decide to have your procedure performed in our endoscopy lab, contact your insurance carrier to ensure that our endoscopy lab is also in network with your insurance plan. Our billing department will assist you with any information your insurance carrier may need to clarify our physician/endoscopy lab's participation with your plan.

If the physician does-not participate with your insurance plan, you will be responsible for payment of all charges at the time of your visit. You will be provided an itemized bill which you may submit to your insurance plan for any reimbursement for which you may be eligible.

Current Insurance and Patient Demographic Information

If your physician participates with your insurance plan, we will file a claim on your behalf and only request payment at the time of service for any co-payments, deductibles, coinsurances or services that are not covered by your plan. For the group to file your insurance, we must have a valid picture ID, the current insurance coverage(s) and be made aware of any changes in either insurance or patient address or phone numbers. **Please bring your insurance card to every visit so that we can confirm your coverage. Otherwise, the visit will be considered self-pay.**

Patient Payment Responsibility For Non-Covered Services

In some cases, your insurance may not cover certain services or may have coverage limits in place. Limited coverage on routine, preventive healthcare is common among insurance plans. We may request payment for any known, non-covered services at the time of your visit; otherwise they will be billed to you at a later date.

Managed Care Insurance (HMO .POS & PPO plans)

Patients with managed care health plans will be expected to follow the payment-at-time-of- service requirements of the particular plan under which they are covered. Managed care patients will not receive monthly statements except for services that are not covered by the plan.

Your managed care plan may require a **referral** from your PCP in order to pay for your visit to a specialist. Please make sure you have obtained any required referrals in advance of your visit. **If** your insurance plan requires a referral and we do not have one, we will try to notify you prior to the visit. **If** we are unable to obtain a referral while you wait, you will be given the option to pay for the visit out of pocket or to reschedule the visit for a later date after the referral can be obtained.

Your managed care plan may also require **prior authorization (precertification)** prior to any outpatient procedures performed by our physicians. Our precertification department will assist in obtaining prior authorization for outpatient services that are considered medically necessary. However, **Screening Colonoscopy** may not be covered by your insurance plan even **if** it is recommended by your physician. You are responsible for calling your insurance carrier to ensure that **routine colonoscopy screenings** are a covered benefit under your insurance plan.

Indemnity Insurance

Our group does not contract with indemnity insurance plans, with the exception of Blue Cross. All other indemnity plans will be filed as a courtesy by our office. If payment is not received within 60 days from the time the claim is filed, the visit will be changed to self-pay status.

Medicare Insurance

Our physicians accept Medicare assignment on covered Medicare charges. Payment for the 20% Medicare coinsurance amount will be billed after we receive payment from Medicare. Payment of the annual deductible or any non-covered charges is expected at the time of service unless you have secondary insurance accepted by the group (see "Secondary Insurance" policy below).

Medicare may not pay for certain services it determines to be medically unnecessary. If there is a possibility that a service to be provided to you may fall into this category, you will be asked to sign an **advanced beneficiary notice** indicating that you acknowledge this possibility and that you agree to pay for all services Medicare determines to be medically unnecessary.

Medicaid & Georgia Better Healthcare Insurances

Patients must show proof of current Georgia Medicaid eligibility (current Medicaid card or DMA964 form) prior to seeing a physician. Co-payments are to be paid at the time of service.

Worker's Compensation Insurance

Validated worker's compensation services are billed either to the employer or the employer's carrier, depending on company policy. In the absence of validation by the employer of a work- related injury, the patient will be held responsible for payment for services rendered. Should the employer or carrier subsequently deny a validated workers compensation service, such charges will be the financial responsibility of the patient.

Secondary Insurance

We file secondary insurance only for plans accepted by the group. We also file all Medigap insurance plans for our Medicare patients. We allow 60 days from the date of service for your secondary payer to pay. Beyond 60 days, unpaid secondary balances are patient responsible.

Signed: _____ Date: _____

Patient/Guarantor

By signing above, the patient or guarantor acknowledges that he/she has read and agrees to comply with all policies above. Please bring this signed form to your appointment.