



— CONSULTANTS IN —
GASTROENTEROLOGY

PATIENT INFORMATION

Name: First _____ MI _____ Last _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

EMAIL: _____ Social Security #: _____ - _____ - _____

Date of Birth (mm/dd/yyyy): ____ / ____ / ____ Sex: M F Ethnicity: _____ Race: _____

Language Spoken: _____ Marital Status: Single Married Divorced Widow Widower

Pharmacy: _____ Address: _____ Phone: (____) _____

Referring Physician: _____ Primary Care Physician: _____

Emergency Contact: _____ Phone:(____) _____ Relationship: _____

INSURANCE INFORMATION (Patient MUST notify the insurance company prior to admission if precertification is necessary.)

Primary Insurance Company: _____ Policy #: _____

Subscriber's Name: _____ Relationship: _____

Subscriber's Date of Birth (mm/dd/yyyy): ____ / ____ / ____

Claim Address: _____ Claim Phone: (____) _____

Secondary Insurance Company: _____ Policy #: _____

Subscriber's Name: _____ Relationship: _____

Subscriber's Date of Birth (mm/dd/yyyy): ____ / ____ / ____

Claim Address: _____ Claim Phone: (____) _____

I certify that all information provided above is correct.

Patient or Responsible Party Signature: _____ Date: _____

PLEASE HAVE OUR RECEPTIONIST MAKE A COPY OF YOUR INSURANCE CARD AND PHOTO ID. THANK YOU.



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PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

Yes No I acknowledge receipt of your Privacy Notice.

I have been provided with a Privacy Notice and understand how my health information is used by the Practice and how my privacy is protected.

Patient or Legal
Representative
Signature: _____

Date: _____

Witness
Signature: _____

Date: _____



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PATIENT FINANCIAL POLICY

Consultants in Gastroenterology and the South Carolina Endoscopy Centers are committed to providing the highest quality of care. The cost of care is expensive and a financial policy is a part of every medical practice.

PATIENT RESPONSIBILITY

Patients are ultimately responsible for all charges for services provided by Consultants in Gastroenterology and South Carolina Endoscopy Centers and payment is due when services are rendered.

If a procedure is scheduled, a non-refundable deposit may be required. This deposit will be applied to any deductible or co-pay that needs to be met.

We have the right to deny treatment that is determined a non-emergency by our physicians for any outstanding balance with either Consultants in Gastroenterology or the South Carolina Endoscopy Centers.

We accept payments by cash, personal check, debit card, VISA, MasterCard and American Express.

INSURED PATIENTS

As a courtesy, we will file your primary and secondary insurance. If we participate with your insurance company, any amount due after the applicable contractual adjustment will be your responsibility. If we do NOT participate with your insurance company, any unpaid balance following insurance payment will be your responsibility.

Please provide us with updated and current information necessary to file your claim. If this is not obtained on the date service is rendered, you may be responsible for your bill. You are also responsible for notifying us of any changes in insurance. A copy of your card is required at each visit. If you do not have your card at the time of visit, you will be asked to sign a waiver and may be billed for the services.

To verify our participation with your insurance, please call your insurance company. Different insurance companies have different co-pays and deductibles. Please be aware of your individual policy requirements. You are required to pay your co-pay and/or deductible at the time of your visit.

We do participate with **Medicare** and file insurance that is secondary to Medicare. It is your responsibility to pay your co-insurance and/or deductible at the time of service.

We are also a participating provider for South Carolina **Medicaid**; however, you must have your current card at the time of service. Your card must have remaining visits left to be valid. Please verify with our office regarding our participation with any HMO Medicaid plan.

It is the patient's responsibility to provide us with the primary care physician referral form. Please check to see if your insurance requires a referral and verify that it is obtained before your visit. If a referral is required, but not obtained, full payment may be required from the patient at the time of service.

If your insurance carrier has NOT paid your claim in full within 60 days, please call your insurance company to inquire about the status.

NON-INSURED PATIENTS

All non-insured patients are required to call (803) 939-4100, ext. 150 or 169 prior to their visit to make payment arrangements. Discounts are offered for prompt payment for the uninsured patient. If arrangements are not made prior to the visit, payment in full is expected at the time of service.

RETURNED CHECKS

You will be charged a \$30 fee in the event your check is returned for any reason.

CANCELLATION AND NO SHOWS

Office Visits: All cancellations must be received at least one (1) business day in advance. Patients who fail to give one (1) business day notice will be considered a "no show" and may be charged \$25.

Procedures: All cancellations for procedures must be received within two (2) business days. Failure to notify the office may result in a \$50 cancellation fee.

COLLECTIONS

We reserve the right to send accounts with balances over 60 days old to an outside collection agency. The agency does have the right to report the past-due balance to the credit bureau.

FOR MORE INFORMATION

If you need more information about our financial policy or have questions, about your financial responsibilities, please call us at (803) 939-4100.

I have acknowledged and read the above policy regarding my financial responsibility to Consultants in Gastroenterology and the South Carolina Endoscopy Centers.

Patient Name (please print): _____ Date (mm/dd/yy): _____

Patient Signature: _____



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PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Please print all information, then sign and date at the bottom.

Patient Name: _____

Address: _____ City: _____ ST: ____ Zip: _____

BirthDate (mm/dd/yy): __/__/__ Home Phone: (____) _____ Work Phone: (____) _____

Purpose of Request

I authorize the Practice to disclose or provide my protected health information to the following individual, who is authorized to act as my personal representative for the purposes of receiving all of my protected health information. I will inform my personal representative of the last four digits of my social security for identification purposes when inquiring about my health information. As my personal representative, they may exercise my right to inspect, copy, and request amendments to my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

Name of Personal Representative:

_____ Phone: _____
Phone: _____
Phone: _____

Description of Information to be Disclosed

I authorize the Practice to disclose all of my protected health information to my designated personal representative.

Expirations or Termination of Authorization

This authorization will remain in effect until terminated by you, your personal representative or another individual (s) of legal entity authorized to do so by court order or law.

Right to Revoke or Terminate

As stated in our Privacy Notice, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Consultants in Gastroenterology

Attn: Privacy Manager
131 Summerplace Drive
West Columbia, SC 29169

Redisclosure

I understand the Practice has no control over the person(s) I have listed as my personal representative. Therefore, any protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the Practice.

Patient Signature: _____ **Date:** _____



PATIENT HISTORY

Providing the following information is very important to your health. Take your time. Complete the information in full and correctly.

Patient Name: _____ Date: _____

CHIEF COMPLAINT

What is the primary reason for this visit?

Seen at the request of: _____

Have you had any previous tests, x-rays or labs? Yes No

If so, explain: _____

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following?

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Colon cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Colon polyps |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease | <input type="checkbox"/> | <input type="checkbox"/> | Other cancers |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacements |
| <input type="checkbox"/> | <input type="checkbox"/> | Gallstones | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Peptic ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Intestinal problems | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric illness |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |

CURRENT MEDICATIONS TAKEN

List all prescription and non-prescription medications.

DRUG ALLERGIES None

SOCIAL HISTORY

- Yes No
- Do you drink alcohol? If yes, how much? _____
- Do you smoke cigarettes? If yes, how much? _____
If you quit, when? _____
- Do you drink caffeinated beverages?
If yes, what? _____ How much? _____
- Are you in a high risk group for contracting HIV or
the AIDS virus? If you don't know, please ask.

FAMILY HISTORY

Has anyone in your immediate family (parents, siblings, children) ever had:

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Colon cancer | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Other cancers | <input type="checkbox"/> | <input type="checkbox"/> | Cirrhosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Peptic ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Gallstones |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric illness |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Lung disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Other digestive disease | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |

DIGESTIVE SYSTEM (for you personally)

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of weight | <input type="checkbox"/> | <input type="checkbox"/> | Pain with meals |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Awaken at night with pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased stress | <input type="checkbox"/> | <input type="checkbox"/> | Frequent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent nausea | <input type="checkbox"/> | <input type="checkbox"/> | Frequent constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Blood in bowel movements |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting blood | <input type="checkbox"/> | <input type="checkbox"/> | Black/tarry stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent indigestion | <input type="checkbox"/> | <input type="checkbox"/> | Take laxatives |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Take antacids |
| <input type="checkbox"/> | <input type="checkbox"/> | When eating, stomach
fills up faster | <input type="checkbox"/> | <input type="checkbox"/> | Change in size/shape/
color of stool |

DO YOU EXPERIENCE ANY OF THE FOLLOWING MORE THAN SIX TIMES A YEAR?

- Yes No
- Visible abdominal bloating
- Incomplete emptying of the bowels
- Mucus in the stool
- Abdominal cramping prior to bowel movements
- Relief of pain with bowel movements
- Abdominal pain related to more frequent, loose
bowel movements

PREVIOUS HOSPITALIZATIONS OR SURGERY

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

I confirm the above is correct and true.

Patient Signature: _____ Date: _____