CONSULTANTS IN
GASTROENTEROLOGY

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:** _____

CONSULTANTS IN GASTROENTEROLOGY

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: _____

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.

CONSULTANTS IN
GASTROENTEROLOGY

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: _____

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 Yes, explain: _____

PAST MEDICAL HISTORY

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

Yes	No		Yes	No	
☐	☐	High blood pressure	☐	☐	Anemia
☐	☐	Diabetes	☐	☐	Colon cancer
☐	☐	Heart disease	☐	☐	Colon polyps
☐	☐	Lung disease	☐	☐	Other cancers
☐	☐	Kidney disease	☐	☐	Joint replacements
☐	☐	Gallstones	☐	☐	Rheumatic fever
☐	☐	Peptic ulcer	☐	☐	Artificial heart valve
☐	☐	Intestinal problems	☐	☐	Psychiatric illness
☐	☐	Thyroid disease	☐	☐	Blood transfusion
☐	☐	Pancreatitis	☐	☐	Bleeding problem
☐	☐	Hemorrhoids	☐	☐	Asthma

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	
☐	☐	Colon cancer	☐	☐	Liver disease
☐	☐	Other cancers	☐	☐	Cirrhosis
☐	☐	Peptic ulcer	☐	☐	Kidney disease
☐	☐	High blood pressure	☐	☐	Gallstones
☐	☐	Diabetes	☐	☐	Psychiatric illness
☐	☐	Heart disease	☐	☐	Lung disease
☐	☐	Other digestive disease	☐	☐	Thyroid disease

PREVIOUS HOSPITALIZATIONS OR SURGERY

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

GASTROINTESTINAL ☐ None of the following

Yes	No		Yes	No	
☐	☐	Heartburn	☐	☐	Indigestion
☐	☐	Nausea	☐	☐	Vomiting
☐	☐	Difficulty swallowing	☐	☐	Pain with eating
☐	☐	Feeling full quickly	☐	☐	Abdominal pain
☐	☐	Abdominal swelling	☐	☐	Abdominal bloating
☐	☐	Constipation	☐	☐	Diarrhea
☐	☐	Change in bowel habits	☐	☐	Rectal bleeding
☐	☐	Hemorrhoids	☐	☐	Rectal pain
☐	☐	Intolerance to wheat/gluten			
☐	☐	Other food intolerance	☐	☐	Jaundice

CONSTITUTIONAL ☐ None of the following

Yes	No		Yes	No	
☐	☐	Weight loss	☐	☐	Weight gain
☐	☐	Fatigue	☐	☐	Fever
☐	☐	Sweats	☐	☐	Chills

ENT ☐ None of the following

☐	☐	Sore Throat	☐	☐	Sinus Problems

CARDIOVASCULAR ☐ None of the following

☐	☐	Chest pain	☐	☐	Palpitations
☐	☐	Shortness of breath	☐	☐	Swelling of legs

RESPIRATORY ☐ None of the following

☐	☐	Cough	☐	☐	Asthma

GENITOURINARY ☐ None of the following

☐	☐	Difficult urination	☐	☐	Frequent urination
☐	☐	Urinary tract infections			

INTEGUMENTARY ☐ None of the following

☐	☐	Rash	☐	☐	Hives
☐	☐	Itching			

HEMATOLOGIC/LYMPHATIC ☐ None of the following

☐	☐	Prolonged bleeding	☐	☐	Easy bruising

NEUROLOGICAL ☐ None of the following

☐	☐	Headache	☐	☐	Fainting
☐	☐	Seizures			

PSYCHIATRIC ☐ None of the following

☐	☐	Depression	☐	☐	Anxiety
☐	☐	Excessive stress			

Patient signature: _____ Date: _____

UNIVERSAL MEDICATION FORM

PLEASE BRING TO YOUR APPOINTMENT COMPLETED

Name:	Address:
Phone:	
Birth Date:	Primary Care Physician:

IMMUNIZATIONS (Record date and year of last immunization, if known.)

Tetanus:	Flu:	Other:
Pneumonia:	Hepatitis:	Other:

ALLERGIES AND REACTIONS **Are you allergic to latex?** ☐ **Yes** ☐ **No**

LIST ALL MEDICATIONS CURRENTLY TAKEN. (Include prescription, over-the-counter (aspirin, antacids, etc.) and herbal medications (vitamins, ginseng). Include medication taken as needed.

DATE	MEDICATION/DOSE	DIRECTIONS/REASON	DATE STOPPED	PRESCRIBING MD

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT.

05/25/2022