GASTROENTEROLOGY & HEPATOLOGY ASSOCIATES, PLLC.

Randy Howard, MD
Scott Hande, MD
Kristin Gaffney, DO
Board Certified Internal Medicine and Gastroenterology

Misti Martinez, MSN, AGPCNP-BC
Board Certified American Nurses Credentialing Center
Amanda Bratcher, FNP-C
Board Certified American Academy of Nurse Practitioners

Dear Mr./Mrs.,

This is a notice to inform you that we have received a request for you to have an:

Open Access Colonoscopy

As you may not have an office visit prior to your procedure, we ask that you do the following:

- Complete and sign the enclosed forms in their entirety including both **FRONT** and **BACK**
- **Mail** or **Fax** (615-826-0910) the completed paperwork to us within 3-5 days.

  Gastroenterology & Hepatology Associates, PLLC.
  107 Glen Oaks Blvd. Suite 202
  Hendersonville, Tn 37075

Please NOTE: If this paperwork is not filled out in its entirety, the process may be delayed. Once your completed paperwork is reviewed, our office will contact you to schedule your appt/procedure. Please contact our office with any questions that you may have.

Sincerely,

Gastroenterology & Hepatology Associates, PLLC

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Please fill out this form in its ENTIRETY:

Name:_____ Current Height: _____ Current Weight: _____lb.

Date of last colonoscopy? _____ Are you currently having any constipation issues? ☐**Y** ☐**N**

Do you have a ***Personal* History** of **colon cancer** ☐**Y** ☐**N** OR **colon polyps**? ☐**Y** ☐**N**
Do you have a ***Family* History** of **colon cancer** ☐**Y** ☐**N** OR **colon polyps**? ☐**Y** ☐**N**

Do you have any medication allergies? ☐**Y** ☐**N** Allergic to: _____ reaction: _____

Have you **EVER** had complications from anesthesia? ☐**Y** ☐**N**
IF YES: What and When? _____

Are you currently on **ANY** of the following? If **YES**, what is your current dose?

Blood Thinners ☐**Y** ☐**N**
*****SUCH AS***** Coumadin/Warfarin, Plavix/Clopidogrel, Savaysa/Edoxaban, Xarelto/Rivaroxaban, Pradaxa/Dabigatran, Eliquis/Apixaban, Brilinta/Ticagrelor, Lovenox or Heparin)
Aspirin ☐**Y** ☐**N**
Seizure Medication ☐**Y** ☐**N**
Cancer Medication ☐**Y** ☐**N**

Are you being followed by a Cardiologist? ☐**Y** ☐**N**
IF YES: Name _____ Phone: _____
Condition(s) being treated: _____

- Do you currently have a **pace maker or defibrillator**? ☐**Y** ☐**N**
- Have you ever had any type of **heart surgery**? ☐**Y** ☐**N**
  - **IF YES:** What type of surgery and date of surgery? _____
- Have you ever had a **stent** placed?
  - **IF YES:** When was it placed? _____

Do you have any type of respiratory conditions (asthma, COPD, etc)? ☐**Y** ☐**N**
IF YES: Pulmonologist Name _____ Phone: _____
Condition being treated: _____

- Are you currently on **oxygen**? ☐**Y** ☐**N**

Patient Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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Patient Registration

Patient Name: _____ Date of Birth: _____ SS# _____

Street Address: _____
City: _____ State:_____ Zip Code: _____

Confidential email: _____

Telephone: (check preferred number) ☐ Home _____ ☐ Work: _____ ☐ Cell:_____

Marital Status (circle one): S M W Separated or D Name of Spouse: _____
Spouse Social:_____ Spouse Employer: _____
Spouse Phone Number: _____

*Sex (circle one): Male, Female, Intersex, MtF Female, or FtM Male
*****Race (please circle one): American Indian, Asian, Native Hawaiian, African American, White, Hispanic, Other
*****Ethnicity (please circle one): Hispanic, Not Hispanic, Refuse to Answer
*****Preferred Language: _____*** Government requires this information to protect patients against discrimination.**

Emergency Contact Name: _____ Relationship to patient:_____
Emergency Contact Phone Number: _____ Cell:_____
Emergency Contact Address:_____

Referred By: _____ Primary Care Physician: _____
Pharmacy Name and Location: _____ Phone: _____

PATIENT EMPLOYER INFORMATION:

Employer Name: _____ Telephone: _____
Patient's Occupation: _____ (Please Circle) Full Part time

POLICY HOLDER'S INFORMATION:

Name: _____ Date of Birth:_____ Social Security #_____
Telephone:_____ Name of Insurance:_____
Subscriber ID#_____ Group#_____ Relationship to Patient: _____

Person(s) I allow my information to be given to: _____

Patient Signature: **X** _____ Date: _____

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RELEASE OF INFORMATION

I authorize Gastroenterology and Hepatology Associates, PLLC to release any medical information from my medical record to any insurance carrier or person employed by such carrier for the purpose of collecting Insurance benefits so long as I am listed on this account as having coverage with such carrier. This authorization includes release of this discharge diagnosis to employers for group insurance coverage, workers compensation carriers and welfare agencies, if applicable to my claim for treatment. I hereby release Gastroenterology and Hepatology Associates, PLLC from any and all responsibility relative to the release of such information. I understand that if my records contain information relating to venereal disease, hepatitis, HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I have the right to revoke this authorization by written notification to the health care provider to which this authorization is submitted. The provider must comply except to the extent that the provider has already acted in reliance upon this authorization.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction for uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

It is our practice to contact patients, and if needed, leaving a message from anything to appointments, outstanding balances, and test results. By signing below, you agree with our practice.

NOTICE OF PRIVACY PRACTICES

I have received a copy, I have ***read***, and ***am aware*** of my rights under the Privacy Practice Law.

Patient Signature: **X** _____

Or, I have been offered a copy and ***declined*** to take the copy of my notice of privacy practices:

Patient Signature: **X** _____

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Notice of missed or rescheduled appointments

Our office policy at Gastroenterology & Hepatology Associates, PLLC. is the following:

- If a patient has ***missed***, ***cancelled***, or ***rescheduled*** an appointment ***or*** procedure ***three times for any reason***, the patient ***may*** be asked to find another provider.

I understand the above information and I understand that if I have missed three appointments, I may be asked to find another provider.

Patient's Signature: **X** _____ Date: _____

Patient's Printed Name: _____

Screening VS. Medical Colonoscopy

Financial Information You Need To Know:

1) Screening benefits for colonoscopies apply when non-medical conditions exist. Any medical condition discovered, (ie: bleeding, constipation, nausea, family history or personal history of cancer or polyps) could be considered by your insurance company as medical and not screening. Depending on your benefits, this could affect your financial responsibility.

2) If your colonoscopy is ordered for routine purposes but polyps are removed or, a medical condition is found- your claim could be considered by your insurance company at your medical benefit vs. the screening benefit. This means that if your screening benefit is 100% and a medical condition was found, then the claim would be paid at the medical benefit instead of the screening benefit. **Please note:** There is no way that we can predict, before a colonoscopy is performed, if polyps or a medical condition will be discovered.

3) Your financial responsibility will not be affected if your insurance covers medical and screening colonoscopies at the same benefit level.

4) Charges rendered by our doctors will be billed directly to your insurance company by our office. The facility bills separately for services that they perform. Our office will send you a bill (if applicable) once your insurance has paid their portion. Any payment due our doctors will need to be sent to our office. Any facility statements/invoices will need to be addressed directly between you and their business office.

I understand the above information and my potential financial responsibility. I understand that my colonoscopy, if deemed medical in nature, would be considered under my medical benefit vs. screening (if the two benefit levels are different).

Patient's Signature: **X** _____ Date: _____

Patient's Printed Name: _____

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Financial Policy

- All copayments and outstanding balances will be due at the time of service. If your copayment is not available, you may be asked to reschedule your appointment. Postdated checks will not be accepted.

- Our practice will work with you on any outstanding balance.

- For amounts less than $500.00, payments will be expected monthly with the balance being paid off within 6 months from your first statement.

- For balances greater than $500, payments will be expected monthly with the balance being paid off within 12 months from your first statement.

- **HOWEVER**: If payments are ***not*** received each month, you will ***not*** be able to see the doctor ***or*** have any medication refills ***until*** your payments are brought up to date.

    - **PLEASE NOTE**: Any account with zero payment activity for three billing cycles, will be sent to our collection agency and a 30% fee may be added to your balance at that time.

    - If your account is turned over to collections your relationship with your provider will be ***terminated*** and you will be given a 30-day window to find another treating physician.

- All self-pay patients are required to pay $150.00 at the time of their first visit. Any balance for this initial visit will be billed to you the following month. The average **estimated** new patient visit is normally $217.75-$274.70.

- All self-pay patients will be required to make a $200 deposit before any elective procedure(s) are scheduled. You will be billed the remainder of the balance within 30 days of the procedure(s). This charge is for our physicians' services only and does **NOT** include facility or anesthesia charges.

I understand the financial policy stated above.

Patient Signature: **X** _____ Date: _____

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SURETY AGREEMENT

- In accordance with the above terms, the undersigned patient and/or undersigned surety, do hereby agree upon demand to pay Gastroenterology and Hepatology Associates PLLC, their agents or assigns whatever sums of money that shall become due on the account of the patient, and that such liability shall be joint and several. I hereby assume responsibility for payment of all medical services rendered by Gastroenterology and Hepatology Associates PLLC. I agree to be responsible for all attorneys and/or collection, the venue of such filing shall be in Sumner County. **If your account is turned over to collections a charge of 30% of the balance may be added to the amount due.**

- I hereby authorize:

  A)The release of any medical information, including protected health information, necessary to process this claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

  B) Any rendering provider of Gastroenterology and Hepatology Associates PLLC to apply for benefits on my behalf. I request that payment from my insurance company be made directly to Gastroenterology and Hepatology Associates, PLLC. (or to the party that accepts assignment.)

  C) That the information I have reported with regards to my Insurance coverage is correct. I recognize that I will be responsible for all charges, whether covered or not by my insurance company.

  D) Gastroenterology and Hepatology Associates, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment.

Patient Signature: **X** _____ Date: _____

OR Parent/Guardian Signature: **X** _____ Date: _____

Relationship to Patient: _____

AUTHORIZATION FOR TREATMENT

I hereby **voluntarily** consent to such clinic care including diagnostic procedures and medical treatment by the physician in charge of mine and/or my child's care.

Patient Signature: **X** _____ Date: _____

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Please list **ALL** Prescription Medications **AND** Over The Counter (OTC) Medications, Vitamins & Supplements that are taken on a regular basis

Patient Name_____ Date Completed_____

Allergies_____

Medication	Dose	Frequency

FOR OFFICE USE ONLY:

Temp_____ Weight_____ Height _____ BP_____ Pulse_____ O2_____