GI PHYSICIANS, INC

Phone: 419-228-2600

Fax: 419-228-1100

LAST NAME: _____FIRST NAME: _____ MIDDLE INTIAL: _____

SOCIAL SECURITY NUMBER: _____RACE: _____ ETHNICITY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE _____ WORK PHONE:_____ CELL PHONE: _____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN (if different than referring):_____

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS: _____ PREFERRED LANGUAGE:_____

How did you hear about our office?_____

EMERGENCY CONTACT (other than spouse)

NAME: _____ RELATIONSHIP: _____ PHONE#:_____

HEALTH INSURANCE: PLEASE BRING CARD(S) TO YOUR APPOINTMENT

PRIMARY INSURANCE NAME: _____ PRIMARY HOLDER: _____

PRIMARY HOLDER'S D.O.B.:_____ EMPLOYER: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CERTIF/ID#:_____ GROUP#_____ INSURANCE PHONE#:_____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURANCE NAME: _____ SECONDARY HOLDER: _____

SECONDARY HOLDER D.O.B.:_____ EMPLOYER: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CERTIF/ID#:_____ GROUP#:_____ INSURANCE PHONE#:_____

INSURANCE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I hereby consent GI Physicians, Inc. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to the physician(s) rendering the covered services. I authorize GI Physicians, Inc., to furnish complete information to my insurance carrier or its intermediaries regarding services rendered. I understand I am financially responsible for all charges not covered by this consent.

I have read (and understand) the payment information. I also give permission to GI PHYSICIANS, INC to use/disclose personal health care information for treatment, payment and/or health care operations.

Signature_____ Date _____

I consent my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communications to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Signature_____ Date _____

GI PHYSICIANS, INC.

FOR WHAT PROBLEM ARE YOU SEEKING CARE? _____

IF PAIN IS PRESENT, PLEASE DESCRIBE: _____HOW OFTEN: _____

SEVERITY (1 MINIMAL-10 SEVERE):_____HOW LONG HAS THIS PROBLEM BEEN PRESENT? _____

QUALITY (i.e. sharp, dull, crampy, burning, achy, etc.)_____

DOES THE PAIN MOVE ANYWHERE? _____

WHAT MAKES PAIN BETTER? _____ WORSE: _____

WEIGHT CHANGE IN THE PAST 6 MONTHS:

Weight Gain: _____ Weight Loss: _____ HEIGHT: _____ WEIGHT: _____

Have you ever had or been treated for: (Circle the problem concerned)

General: Fever, chills, weight loss, night sweats.

Eyes: Cataracts, double vision, glaucoma, pain on exposure to light, loss of vision.

Ear, Nose, **Throat:** Hearing loss, sinus infections, nasal polyps, hoarseness.

Cardiovascular: High blood pressure, heart disease, heart murmur, angina, chest pains, rheumatic fever, defibrillator.

Respiratory: Pleurisy, TB, coughing up blood, asthma, emphysema, bronchitis, shortness of breath, chronic cough.

Gastrointestinal: Swallowing trouble, heartburn, belching, gas, duodenal or gastric ulcer, abdominal pain, liver disease, jaundice, hepatitis, gallbladder disease, constipation, diarrhea, black stools, blood in stools, change in bowel habits, incontinence (loss of control of bowel movements).

Genitourinary: Kidney or bladder infections, blood in urine, kidney stones, nephritis, incontinence, prostate trouble, sexual problems, sexually transmitted disease, extramarital activity, homosexual activity.

Gynecologic: Abnormal menstrual bleeding, irregular periods, painful intercourse, frequent pelvic infections, endometriosis. List date of last menstrual period. _____

Musculoskeletal: Painful or swollen joints, arthritis.

Skin and Breast: Rashes, psoriasis, melanoma, tattoos, breast lumps, breast cancer, skin cancer.

Neurological: Frequent headaches, migraines, epilepsy, seizures, passing out or dizzy spells, numbness or tingling of arms or legs, stroke.

Emotional: Sexual, physical or emotional abuse, depression, anxiety, excessive nervousness, marital problems, crying spells, suicidal thoughts, in-law problems.

Endocrine: Diabetes, thyroid disease.

Blood: Anemia, bleeding disorder, blood or blood product transfusion.

Allergic/Immunologic: Lupus, HIV (AIDS).

Cancer: Any previous cancers. Please list. _____

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Approximate Date of Last: Physical Exam_____ Gallbladder_____
Electrocardiogram_____ Sigmoidoscopy_____
Chest X-Ray_____ Colonoscopy_____
Barium Enema_____ GI Series_____

Do you have a history of heart valve problems or need antibiotics before procedures?_____
Please list your heart doctor's name and phone number_____
List Drug Allergies_____ None Known_____
Do you have a history of allergy or reactions to X-Ray dye or iodine? _____
Are you sensitive or allergic to latex, iodine, tape, or shellfish?
_____

List chronologically all operations and all hospitalizations (use separate sheet of paper if needed)

Approx Date	Operation and/or Diagnosis	Hospital	Physician

PLEASE BRING CURRENT MEDICATIONS WITH YOU
List all **medications/dosages taken**, when started and/if stopped including Motrin, Advil, Aleve, or all other "pain" meds, vitamins, laxatives, antacids, and birth control pills. **(Please use additional paper if needed)**
_____
_____

Tobacco:___pk(s)/day for___yr(s) Soft Drinks:____oz(s)/day
Alcohol: Type_____ Amount_____ Street Drugs_____

FAMILY HISTORY

	Age	State of Health & Diagnosis	Age at Death and Cause
Father			
Mother			
Brother or Sister			
Brother or Sister			
Brother or Sister			

Father's Father			
Father's Mother			
Mother's Father			
Mother's Mother			

Spouse			
Son or Daughter			
Son or Daughter			
Son or Daughter			

Does anyone in your family have history of colon polyps____ or colon cancer_____? (Please check). If yes, please list how related_____

GI PHYSICIANS, INC.

In these times of constant changes of health coverage, much confusion can arise in the area of insurance claims and payments. We have tried to lessen some of the frustration by providing the following information:

Our office will be happy to pre-certify outpatient procedures; however, you are responsible for checking with your insurance company regarding coverage and benefits. If you are scheduled for screening or preventative services, PLEASE VERIFY WITH YOUR INSURANCE CARRIER THAT SCREENING OR PREVENTATIVE SERVICES ARE A COVERED BENEFIT UNDER YOUR PLAN. Some insurance companies may not cover these types of services.

PAYMENTS: We accept cash, VISA/MasterCard, or check (please make payable to: GI Physicians, Inc.)
There may be an additional charge if hemoccult or anoscopy are performed. You are responsible for timely payment of your account. **We reserve the right to reschedule or deny a future appointment on delinquent accounts.**

If your insurance card has any of the following: **PCP, Primary Physician, Managed Care, or HMO,** you may need an authorization from your family doctor before you can be seen. If you find the above letters or wording on your card, please call your family physician to be sure an authorization has been issued allowing you to be seen by one of our doctors.

SELF PAY: If you have no insurance, we require a $100.00 down payment on the date of your first visit, and a $50.00 payment on each subsequent visits. A payment plan will be established the date of your visit to ensure timely payments on the rest of your balance. Before a colonoscopy or EGD can be scheduled, we require a $100.00 down deposit. If both a colonoscopy and EGD are to be scheduled, we require $150.00 down deposit.

MEDICARE: We do accept assignment on Medicare. We file the Medicare claim; the payment comes to us; we take any necessary write-offs. Medicare patients are responsible for the 20% balance after Medicare has processed charges and any deductibles which have been applied. If you have supplement insurance we will file the claim if Medicare doesn't automatically.

MEDICAID: We do accept Medicaid patients; however, you must have your card with you at each visit. **PLEASE VERIFY WE ARE IN-NETWORK WITH THE NEW MANAGED CARE PLANS OR YOUR VISIT WILL NOT BE COVERED.**

ALL INSURANCE: We will be happy to file your office visit charges to your insurance; however, we ask that any **co-pay, deductibles, or uncovered services be paid at the time of visit.** All services which we provide at the hospitals are filed to your insurance company. Follow up visits are billed separately, they are not included in any other service provided.

WORKER'S COMPENSATION: We do accept Worker's Compensation patients but would like to advise that our diagnosis codes (gastroenterology) are many times not allowed by Workers' Compensation. If you feel your visits with us are due to a work-related problem, please check with the caseworker who is handling your claims to be sure your services will be covered.

Effective as of August 27, 2015

Any no show or cancellation without a 24 hour notice will be charged as the following: New Patient: $50.00. Follow up: $25.00. This cannot be billed to the insurance company and must be paid before scheduling a new appointment.