SUMMIT GASTROENTEROLOGY

This form must come with you to your appointment.

PATIENT INFORMATION Please complete and bring these forms to your appointment

Date of visit _____ ( ) New Patient ( ) Update

Name: Mr./Mrs./Ms. _____
Last First Middle

Address _____
Street City State Zip

Social Security Number: _____ Date of Birth: _____ Age: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Employer Address _____

Marital Status _____ Spouse Name _____

Spouse's Employer _____ Occupation _____

Address _____ Phone _____

Emergency Contact (not in the same household) _____

Relationship _____ Home Phone _____ Work Phone _____

Referring Physician _____ Phone _____

Your E-Mail Address _____

MEDICAL INSURANCE INFORMATION

Please fill out the following section completely. Your insurance company will not pay if we do not have the correct information.

Primary Insurance Company _____

Member, ID or Policy Number _____ Group Number _____

Policyholder _____ Relationship to patient _____ Policyholder DOB _____

Policyholder's Social Security Number _____

Secondary Insurance Company _____

Member, ID or Policy Number _____ Group Number _____

Policyholder _____ Relationship to patient _____ Policyholder DOB _____

Policyholder's Social Security Number _____

If the patient is not the responsible party (i.e. patient is a minor or has someone as a Power of Attorney) — please fill out the following three lines with the information of the party responsible for the care of the patient.

Name: Mr./Mrs./Ms. _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Patient's or Responsible Party – please sign below:
Authorization – I have read and agree to the terms and conditions of this form and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to the provider of services. I understand that I am financially responsible to ***Summit Gastroenterology*** for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collections and/or court costs and reasonable fees should this be required.

A COPY OF THIS DOCUMENT AND THE SIGNATURE BELOW SHALL BE TREATED AS AN ORIGINAL.

Responsible Party/Guarantor's Signature_____ Date_____

Financial Policy

We would like to take this opportunity to welcome you to our office, and to let you know that we are committed to providing you with the best possible care. So there is no misunderstanding as to what our Financial Policy is, please take this opportunity to read this information. We will gladly discuss your proposed treatment and answer any questions related to your insurance.

If you have no insurance, payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. To assist you, we accept cash, checks, MasterCard, Discover and Visa. Co-pays are due at the time of service.

If you have insurance, we will promptly file it for you as a courtesy, provided we have your assignment of benefits. You must realize, however, that your insurance coverage is a contract between you and the insurance company. Payment to us is your responsibility. If your insurance has not remitted payment to us at the end of thirty working days, regardless of appeals or other delays, payment will be due in full from you. Balances beyond thirty days are subject to a $25 late fee and a 1% monthly interest charge. You are responsible for all legal and collection fees, if any, needed to settle your account. Please keep in mind that not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. If in doubt, please check with your insurance carrier for details regarding your specific benefits.

If you belong to an HMO or PPO, we follow the guidelines set forth in these plans. If it is applicable, please be sure to bring a referral form with you to your appointment. Services cannot be rendered if proper authorization hasn't been given. ***If you have UHC Military West (TRICARE) you are responsible for obtaining a referral from your PCM (Primary care manager) to be seen by our specialists. Bring this referral with you to our office at the time of your appointment. If not obtained, you may be responsible for services rendered.**

We realize that temporary financial problems may affect timely payment of your balance. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We do use outside agencies as a means of collection should we deem it necessary. You agree that if this account is not paid in full, and Summit Gastroenterology should retain an attorney or collection agency for collection, you agree to pay all costs of collection including reasonable interest, reasonable attorney's fees (even if suit is filed) and reasonable collection agency fees.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. Your signature below ensures understanding and compliance with this policy.

_____ _____
Signature ***Date***

*** Cancellation Policy: $25 fee for cancelled office appointments with less than 24 hours notification; $50 fee for cancellation of endoscopy appointments with less than 48 hours notification.**

****Arrive 15 minutes prior to your appointment time. You may be asked to reschedule if you are late.**

Patient_____ Referring Physician_____

Age_____ Date of Birth_____ Male_____ Female _____

Last abdomen sono _____ N/A _____ Facility Performed _____

Last CT Abdomen/Pelvis _____ N/A _____ Facility Performed _____

Last GI Test (colon, EGD, ERCP, Flex sigmoidoscopy, Barium Enema)_____N/A _____

Facility Performed _____ Year of Last Complete Medical Exam _____

Reason for Visit (symptoms)

_____

_____

_____

Patient Profile

☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Ethnic Origin: ☐ Asian ☐ Caucasian ☐ Black or African American ☐ American Indian/Alaska Native ☐ Hispanic Latino
☐ Native Hawaiian/Pacific Islander ☐ Multi-racial (two or more race) ☐ Unknown or patient refused

Religious Preference _____ Language Preference _____

Occupation _____ Years Retired _____

Habits: Smoking: ☐ Current ☐ Never smoked ☐ Former Smoker, when stopped _____
Coffee: ☐ None ☐ More than 2 cups per day
Alcohol: ☐ 1 oz./Day ☐ 2 oz./Day ☐ 4 oz./Day ☐ Over 6 oz./Day ☐ None
Beer: ☐ 1/Day ☐ 2/Day ☐ More than 4/Day

Medicines

List all medicines take daily or routinely with or without prescriptions including birth control pills or vitamins, aspirin and pain pills. Include additional meds on separate sheet.

Medication Name	Dose	Frequency

Medication Name	Dose	Frequency

Preferred Pharmacy

We are implementing electronic prescribing; Please provide the following information:

Primary Pharmacy Name _____ Phone # _____

Address _____ City/State/ZIP _____

Allergies

List all medications you are allergic to: _____

_____

☐ No Known Drug Allergies

Tuberculosis History

Positive TB Skin Test..... ☐ Yes ☐ No Exposed to someone with active TB .....☐ Yes ☐ No

Previously diagnosed with TB .....☐ Yes ☐ No

If yes, have you had: A cough that has lasted longer than 3 weeks.....☐ Yes ☐ No Unexplained fevers.....☐ Yes ☐ No

Unexplained weight loss.....☐ Yes ☐ No Night sweats .....☐ Yes ☐ No

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

Revised October 5, 2013

I understand the Health Insurance Portability and Accountability Act of 1994 (HIPAA), I have certain patient rights regarding my protected health information.

I understand that ***Summit Gastroenterology*** may use or disclose my protected health information treatment, payment or health care operations - which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Summit Gastroenterology has a detailed document called the *Notice of Privacy Practice*s. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the Notice before signing this agreement. If I ask, ***Summit Gastroenterology*** will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow ***Summit Gastroenterology*** to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that ***Summit Gastroenterology*** has taken action relying on this consent.

_____ _____

Signature (Patient or Legal Custodian/Authorized Representative) ***Date***

_____ _____

Printed Patient Name ***DOB***

_____ _____

Relationship to Patient (If signed by another party) ***Date***

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time. Contact Summit Gastroenterology at (816)554-3838.

Summit Gastroenterology
110 NE St. Luke's Blvd., Suite 530
Lee's Summit, MO 64086
P: 816-554-3838
F: 816-554-1634

Consent for Release of Information for Treatment, Payment and Health Care Operations

I,_____, hereby authorize ***Summit Gastroenterology*** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, ***Summit Gastroenterology*** can refuse to treat me. I have been informed that ***Summit Gastroenterology*** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying our Office Manager, in writing, but if I revoke my consent, such revocation will not affect any actions that ***Summit Gastroenterology*** took before receiving my revocation. I understand that ***Summit Gastroenterology*** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that ***Summit Gastroenterology*** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment and health operations. I understand that ***Summit Gastroenterology*** does not have to agree to such restrictions, but that such restrictions are agreed to, ***Summit Gastroenterology*** must adhere to such restrictions.

_____ _____

Signature of Patient or Patient's Representative ***Date***

_____ _____

Printed Name of Patient or Patient's Representative ***Relationship to Patient***

Authorization To Release Information

I hereby authorize the use or disclosure of my individually identifiable health information to the following individuals:

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that this authorization is voluntary and can be revoked in writing at any time.

_____ _____

Signature ***Date***

Can we leave messages on your answering machine/voicemail at your home/work regarding your appointments?

☐ Yes ☐ No

Authorization for Release of Medical Information

This consent to release information about a patient is intended to satisfy the requirements of Kansas, Missouri and federal law.

I understand that my medical record includes confidential information pertaining to all aspects of my medical care, including information regarding visits to my physician, referrals to consultants, as well as laboratory, x- ray and drug testing.

Name _____ Date of Birth _____

Address _____ Phone (H) _____

City/State/Zip _____ Phone (W) _____

I, the undersigned, hereby authorize _____

Address _____ City/State/Zip _____

To release to SUMMIT GASTROENTEROLOGY
110 NE Saint Luke's Blvd, Suite 530
Lee's Summit, MO 64086
P: 816-554-3838
F: 816-554-1634

The following information pertaining to my medical care:

_____ Complete medical record	_____ Partial (please specify)
_____ Laboratory	_____ Progress Notes
_____ Procedure Notes	_____ Radiology
_____ Biopsy results	_____ Letter
_____ Hospital (dictation)	_____ Other (please specify)_____

_____ _____
Patient's Signature ***Date***

_____ _____
Parent/Legal Guardian/Representative ***Relationship*** ***Date***

_____ pt arrival
_____ chart to MA
_____ MA complete

PATIENT HISTORY

Today's Date _____

PATIENT: _____ REFERRING PHYSICIAN: _____ AGE: _____ DATE OF BIRTH: _____

Reason for Today's visit: _____ PHARMACY: _____

HABITS: Smoking Status: ☐ never smoker ☐ former smoker ☐ current smoker History of Drug Use _____

Smokeless Tobacco Use: Y/N Amount per day: _____ Last Colonoscopy: _____ Last EGD: _____

Alcohol Use: Y/N Amount per day: _____ Last Flu Vaccine: _____ Last Pneumonia Vaccine: _____

Medical History *(circle all that apply)*

Anemia
Asthma
Barrett's Esophagus
Cardiac Stents
Celiac Sprue
Cirrhosis
Colon Cancer
Colon Polyps
COPD
Coronary Heart Disease
CVA/Stroke
Crohn's
Depression
Diabetes
Diverticulitis
Diverticulosis
Enlarged Prostate
Fibromyalgia
Gastroparesis
Gerd
Glaucoma
Heart Murmur
Hemochromatosis
Hemorrhoids
Hepititis A/B/C
High Blood Pressure
High Cholesterol
Kidney Disease
Kidney Stones
Liver Disease
MI
Osteoarthritis
Osteroporosis
Pacemaker/Defibrillator
PUD
PVD
RA
Seasonal Allergies
Seizures
Sleep Apnea
Cancer Location: _____
_____

Surgical History *(circle all that apply)*

Anesthesia Problem: Yes
Anesthesia Problem: No
Appendix
Aortic Valve Replacement
Back
Brain
C-Section
CABG
Cardiac Stent
Carpal Tunnel
Cataracts
Colon
EGD
ERCP
Esophagus
Flex Sigmoidoscopy
Gall Bladder
Gastric Bypass
Heart
Hemorrhoids
Hernia/Groin
Hip
Knee
Laparoscopy
Mitral Valve Replacement
Pacemaker
Prostate
Rotator Cuff
Stents
Stomach
Thyroid
Tonsils
Tubal Ligation
Vertebroplasty
Weight Loss Surgery
Other Surgeries: _____

Family History

GI Cancer:				
Colon	☐ Father	☐ Mother	☐ Brother	☐ Sister
Esophagus	☐ Father	☐ Mother	☐ Brother	☐ Sister
Liver	☐ Father	☐ Mother	☐ Brother	☐ Sister
Pancreas	☐ Father	☐ Mother	☐ Brother	☐ Sister
GI Illnesses:				
Polyps	☐ Father	☐ Mother	☐ Brother	☐ Sister
Anemia	☐ Father	☐ Mother	☐ Brother	☐ Sister
Crohns	☐ Father	☐ Mother	☐ Brother	☐ Sister
Ulcerative Colitis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Other:				
Bleeding Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister
Breast Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Hemachromatosis	☐ Father	☐ Mother	☐ Brother	☐ Sister
Hypertension	☐ Father	☐ Mother	☐ Brother	☐ Sister
Prostate Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Ovarian Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister

Recent Symptoms *(within last 1-3 months - circle all that apply)*

General
Anorexia
Chills
Fatigue
Fever
Sweats

Eyes
Blurring
Discharge
Double Vision
Eye Pain
Irritation
Photophobia
Vision Loss

ENT
Hoarseness
Loss of Hearing
Nasal Congestion
Ringing in Ears
Sore Throat
Sores in Mouth

Cardiovascular
Blood clots
Chest pain
Dyspnea
Orthopnea
Palpitations
Peripheral Edema
Syncope

Respiratory
Cough
Dyspnea
Excessive Sputum
Wheezing

Gastrointestinal
Abdominal distention
Abdominal Pain
Belching
Blood in stool
C-Diff Colitis
Change in Bowel Habits
Constipation
Diarrhea
Difficulty Swallowing
Early Satiety
Fecal Incontinence
Food/Milk Intolerance
Gas/Bloating
H pylori
Heartburn
Hernia
Irregular Bowel Habits
Jaundice
Nausea
Pain with Bowel Movement
Polyps
Ulcers
Vomiting
Vomiting Blood
Other _____

Genitourinary
Incontinence
Kidney/Bladder Infections
Kidney Stones
Urinary Frequency
Urinary Hesitancy

Musculoskeletal
Arthritis
Fibromyalgia
Osteopenia
Osteoporosis
TMJ

Skin
Dry Skin
Itching
Rash
Suspicious Lesions

Neurologic
Dizziness
Lack of Coordination
Memory Loss
Neuropathy
Restless Leg Syndrome
Seizures
Stroke/TIA
Tremors
Vertigo
Weakness

Psychiatric
Anxiety
Bipolar
Depression
Emotional Problems

Endocrine
Cold Intolerance
Diabetes
Excessive Thirst
Heat Intolerance
Thyroid Problems

Hematologic
Bleeding
Bruising
Enlarged Lymph Nodes
Personal History of Cancer

Allergy
Seasonal Allergies