Gastroenterology Associates of Gainesville, P.C.

MRN: ___________
(For internal use only)

# PATIENT REGISTRATION FORM

| Date: | Reason for Visit: |
|---|---|

| LAST NAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| | | |

| SOCIAL SECURITY # | SEX ○ Male ○ Female | I IDENTIFY MYSELF AS: ○ Male ○ Female ○ Other: ___________ | BIRTH DATE (mm/dd/yyyy) | |
|---|---|---|---|---|
| MAILING ADDRESS | CITY | | STATE | ZIP |

| HOME PHONE | WORK PHONE | MOBILE PHONE | E-MAIL ADDRESS |
|---|---|---|---|
| | | | |

| MARITAL STATUS ○ M ○ S ○ D ○ W | INTERPRETER NEEDED? ○ Yes ○ No | PREFERRED LANGUAGE | RACE | ETHNICITY |
|---|---|---|---|---|
| | | | | |

| RELIGION | COMMUNICATION PREFERENCE | PRIMARY CARE PHYSICIAN |
|---|---|---|
| | | |

## EMPLOYER INFORMATION

| PATIENT'S EMPLOYER | OCCUPATION | WORK PHONE | |
|---|---|---|---|
| BUSINESS ADDRESS | CITY | STATE | ZIP |

## EMERGENCY CONTACT INFORMATION

| NAME | RELATIONSHIP | HOME PHONE | WORK PHONE | MOBILE PHONE |
|---|---|---|---|---|
| | | | | |

## GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OLD)

| GUARANTOR'S NAME | RELATIONSHIP | SOCIAL SECURITY # |
|---|---|---|
| ADDRESS (IF DIFFERENT FROM ABOVE) | DATE OF BIRTH | SEX |

| EMPLOYER | HOME PHONE | WORK PHONE | MOBILE PHONE |
|---|---|---|---|
| | | | |

| EMPLOYER'S ADDRESS | CITY | STATE | ZIP | NAME OF ADULT PRESENTING MINOR FOR TREATMENT | RELATIONSHIP |
|---|---|---|---|---|---|
| | | | | | |

## INSURANCE INFORMATION

| INSURANCE COMPANY (PAYOR) | SUBSCRIBER NAME | DATE OF BIRTH | SOCIAL SECURITY # | SUBSCRIBER ID | GROUP ID | PATIENT RELATIONSHIP TO SUBSCRIBER ○Self ○Spouse ○Child ○Other |
|---|---|---|---|---|---|---|
| SECONDARY INSURANCE (PAYOR) | SUBSCRIBER NAME | DATE OF BIRTH | SOCIAL SECURITY # | SUBSCRIBER ID | GROUP ID | PATIENT RELATIONSHIP TO SUBSCRIBER ○Self ○Spouse ○Child ○Other |

## REFERRAL INFORMATION

Referred to Gastroenterology Associates of Gainesville, P.C. by:

How did you hear about our office?

**PLEASE READ THE FOLLOWING INFORMATION CAREFULLY**

I certify that the above information is correct. I consent to be treated by the staff and providers of Gastroenterology Associates of Gainesville, P.C. and its affiliates, agents, contractors, or business associates. I understand that the insurance(s) information I have provided is the insurance(s) in which will be filed. If there are changes to my insurance(s), it is my responsibility to update the information in a timely manner. Any denials due to inaccurate information will be patient responsibility. An electronic copy of this authorization shall be considered as effective and valid as the original.

**PATIENT/GUARANTOR SIGNATURE*** ______________________________________ **DATE:** _________

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE.



In partnership with Northeast Georgia Physicians Group

Gastroenterology Associates of Gainesville, P.C.

MRN: __________
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## ANNUAL CONSENT/AUTHORIZATIONS

Patient Name: ________________________________________________ DOB: _______________

### Consent for Treatment:

- Permission is hereby given for any medical / surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, Nurse Practitioner, or Nurse Midwife.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

### Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

Tell us with whom we may discuss your protected health information: *(Name and relation.Example: Jane Doe, Wife; Jan Doe, Daughter)*

1) Name: ______________________________ Relationship: _________________ Phone #: ___________________
2) Name: ______________________________ Relationship: _________________ Phone #: ___________________
3) Name: ______________________________ Relationship: _________________ Phone #: ___________________

*This authorization and all other agreements on this form shall remain in effect until revoked by me in writing. An electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization at any time.*

- If you do not authorize information to be released to anyone please check this statement.
  - ☐ I do not authorize any information to be released to anyone other than myself.
- For Medical Records release, see form GA/C-45.

### Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received. I hereby authorize any insurance benefits to be paid directly to Northeast Georgia Physicians Group, Gastroenterology Associates of Gainesville, P.C. and any of their affiliates, agents, contractors or business associates and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

I hereby authorize Northeast Georgia Physicians Group, Gastroenterology Associates of Gainesville, P.C. or any of their affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received by Gastroenterology Associates of Gainesville, P.C., or any of its affiliates, agents, contractors or business associates or the payment for the services I received by Gastroenterology Associates of Gainesville, P.C., or any of its affiliates, agents, contractors or business associates including but not limited to, debt collection purposes.

### Acknowledgment of Receipt of Nondiscriminatory Act Notice:

☐ By initialing, I acknowledge that I am aware of the Nondiscriminatory Act Notice and have the right to be provided with a copy of the notice upon my request.

### Acknowledgement of Privacy Rights:

By signing below I acknowledge that I am aware of the NGHS/Gastroenterology Associates of Gainesville, P.C. Notice of Privacy Practices and Individual Rights. We may use or share your medical information with personnel involved in your care at the practice. We may also disclose your medical information to people outside of the System, such as Health Information Exchanges. NGHS/Gastroenterology Associates of Gainesville, P.C. Notice of Privacy Practices contains more information about the policies and practices protecting the patient's privacy.

**I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.**

**Signature:** ______________________________________________________ **Date:** __________

**Print Name:** ___________________________________ **Email address:** ____________________________

Gastroenterology Associates of Gainesville, P.C.

MRN: «PNumber»
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# POLICIES ACKNOWLEDGMENT

**Please read over our payment policy below and initial where required.**
**Your initials tell us that you agree to comply with these parts of the policy.**

## Payment Policy _______ Initials

1. In compliance with new Federal law, we will ask you for photo identification and proof of health insurance at every visit. We may also take your picture the first time you visit our office.
2. It is not feasible for our staff to be fully aware of each health insurance plan's specific requirements or coverages. We will do everything we can to help you; however, it is your responsibility to verify that NGPG, Gastroenterology Associates of Gainesville, P.C., or their affiliates, agents, contractors or business partners are part of your insurance plan's covered providers, and to know what your plan does and doesn't cover.
3. It is your responsibility to know what limitations your insurance plan may place on the number of times you can be seen in the office, have treatments performed, when referrals are required to receive care, or receive other types of health care.
4. Any charges you incur with us that are not paid by your health insurance according to our existing agreements will be your responsibility to pay. We will bill your insurance plan as a courtesy to you.
5. If you do not have health insurance, we will be happy to provide care for you. We offer a discount to uninsured patients on those services that would typically be billed to an insurance company. In order to qualify for this discount, we require a minimum of $100.00 to be paid at check-in. This payment will be applied towards any charges for your visit. If you are not able to make the minimum payment at check-in, you will be asked to reschedule your appointment unless you have an urgent need to be seen.
6. We will continue to provide care for you while you are paying off any outstanding balances owed. You will need to pay in full any charges you incur at the time of service while you are paying off outstanding balances. An exception may be made if your provider determines your visit is urgently needed. If you are unable to pay in full at the time of service, please ask about our payment options.
7. We do use a collection agency for accounts that fail to make a good faith effort to pay for the medical services we provide.

## Prescription Refill Policy _______ Initials

Please allow 48 hours for all prescription refills. To speed up the process, please ask your pharmacy to send a refill request to the clinic.

## Medical Records Policy _______ Initials

We are happy to provide you with a copy of your medical records. You must first provide a properly verified signed release of information for copies provided via email, CD, or on paper. A cost may be associated depending on the number of pages requested.

## Changes in your Personal Information _______ Initials

You are responsible for informing us of any changes to your name, address, telephone number, email address, or health insurance coverage. A failure to do so may affect your insurance coverage and/or our ability to provide you with important information about your health.

Patient Name: ______________________________________________ Date of Birth: __________

Patient Signature: ______________________________________________ Date: _________

Parent/Legal Representative Signature: ________________________________ Date: __________

Gastroenterology Associates of Gainesville, P.C.

MRN: «PNumber»
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## PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Gastroenterology Associates of Gainesville, P.C. for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible. The following information outlines our expectations for your financial responsibility to our office.

Patients or their legal representatives are ultimately responsible for all charges for services rendered. All services rendered to minor patients will be the responsibility of the accompanying adult, custodial parent or legal guardian.

Gastroenterology Associates of Gainesville, P.C. and Northeast Georgia Physicians Group are contractually obligated to collect applicable co-payments at the time services are rendered. We are also obligated to collect any deductible and/or co-insurance amounts deemed patient responsibility by your insurance.

Uninsured (self-pay) patients will have a minimum time of service payment of $100 due at check-in. This payment will be applied towards the services rendered that day. If charges for services exceed the minimum time of service payment collected, you will receive a statement for the balance. We do provide a 30% self-pay discount to patients that pay their minimum time of service payment.

***Procedure Deposit:*** Patients who are scheduled for a procedure may be required to pay a deposit towards their estimated patient responsibility amount. This amount would consist of any applicable co-pays, co-insurance, or any remaining deductible amounts. Our staff will contact your insurance company and provide you with an estimate of the planned procedure fee based on your plan benefits. The procedure deposit may be paid by cash, check or credit card.

You will also be contacted by hospital staff that will provide the same information for your expected hospital charges.

Please be aware that you may receive a statement from other entities such as anesthesia, lab, pathology, etc. Any questions you have regarding those charges would need to be directed to the billing entity. Gastroenterology Associates of Gainesville, P.C. does not process the billing for anesthesia, labs, most physician services, pathology (*depending on your insurance plan*), and facility charges.

If you are unable to pay 100% of the estimate amount prior to your procedure, our staff will provide you with information about financing options. You will be required to make some type of payment towards your estimate amount prior to your procedure.

Dr. Scott Clark, Dr. Sheraj Jacob, Dr. Vinayasekhara Reddy, Dr. John Kalarickal, Dr. Namita Pareek, Dr. Neeraj Sharma, Dr. Ankur Sheth, and Dr. Andrew Lake are the owners of Gainesville Endoscopy Center, LLC and Braselton Endoscopy Center, LLC. They have a financial interest in these facilities. If you wish to be scheduled at another location please inform our office at the time of scheduling.

In the event your account incurs a credit for one affiliate of Gastroenterology Associates of Gainesville, P.C. and a deficit for another, we reserve the right to transfer credit to any outstanding balance prior to issuing a refund.

**By signing this form, you agree that you have read and understand your financial responsibility.**

Patient Name: ______________________________________________ Date of Birth: ________________

**Patient Signature:** ____________________________________________________________ Date: _________

**Parent/Legal Representative Signature:** _____________________________________________ Date: _________

Gastroenterology Associates of Gainesville, P.C.

# Medical Information Sheet

**Patient Name:** ___________________ **DOB:** __________ **MRN:** __________ **Date:** __________

**Primary Care Physician:** ___________________ **Referring Physician:** ___________________

**Reason for visit:** ______________ **Where is the problem located:** __________ **For how long:** __________

**Pharmacy:** ___________________ **Pharmacy Location**: ___________________

**Does anything make it better:** ___________________ **Worse:** ___________________

**Have you had past surgeries? What kind/When:** ___________________

___________________

___________________

___________________

**Have you had a flu shot in the past year:** □ Yes ___ /_____ (*mo / year*) □**No** **Have you had a Pneumonia shot:** □ Yes ________ (*year*) □ No

| | | | | | |
|---|---|---|---|---|---|
| Have you **ever** smoked? | □Yes | □No | Do you **currently** smoke? | □Yes | □No |
| Have you **ever** consumed alcohol? | □Yes | □No | Do you **currently** drink alcohol? | □Yes | □No |
| Have you **ever** used injection/recreational drugs? | □Yes | □No | Do you **currently** use drugs? | □Yes | □No |

**Does your family have history of the following cancers, if so who:** ___________________

**What type:** □ Colon □ Stomach □ Liver □ Pancreas □ Breast □ Ovarian □ Uterine □ Brain

**Are you currently experiencing any of the following symptoms?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Headaches | □ Yes | □ No | Dizziness | □ Yes | □ No | Numbness/Tingling | □ Yes | □ No |
| Fever/chills | □ Yes | □ No | Chest Pain | □ Yes | □ No | Swollen Lymph Nodes | □ Yes | □ No |
| Blurred/Double Vision | □ Yes | □ No | Shortness of Breath | □ Yes | □ No | Swollen Glands | □ Yes | □ No |
| Bleeding Gums | □ Yes | □ No | Sore Throat | □ Yes | □ No | Difficulty/bloody Urine | □ Yes | □ No |
| Abdominal Pain | □ Yes | □ No | Change in Appetite | □ Yes | □ No | Nausea | □ Yes | □ No |
| Reflux/Heart Burn | □ Yes | □ No | Excessive Gas | □ Yes | □ No | Vomiting | □ Yes | □ No |
| Difficulty Swallowing | □ Yes | □ No | Loose Stools | □ Yes | □ No | Bloating | □ Yes | □ No |
| Blood on Toilet Paper | □ Yes | □ No | Blood in Stool | □ Yes | □ No | Hard Stools | □ Yes | □ No |

**Change in Weight:** □ Yes □ No If yes, please explain: ___________________

**Change in Color/Shape/Consistency of Stool:** □ Yes □ No If yes, please explain: ___________________

**Do you have a history of or have you ever been treated for any of the following?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | □ Yes | □ No | Chronic Back Pain | □ Yes | □ No | Seizures | □ Yes | □ No |
| Diabetes | □ Yes | □ No | Arthritis | □ Yes | □ No | Glaucoma | □ Yes | □ No |
| High Cholesterol | □ Yes | □ No | Stroke | □ Yes | □ No | Cataract | □ Yes | □ No |
| Sleep Apnea | □ Yes | □ No | Depression | □ Yes | □ No | Thyroid Disorder | □ Yes | □ No |
| COPD/Emphysema/Bronchitis | □ Yes | □ No | Hepatitis | □ Yes | □ No | Blood Clots(lungs/legs) | □ Yes | □ No |
| Congestive Heart Failure (CHF) | □ Yes | □ No | Jaundice | □ Yes | □ No | Cancer | □ Yes | □ No |
| Fibromyalgia | □ Yes | □ No | **Other Disorders** | ___________________ | | | | |
| Bleeding Disorder | □ Yes | □ No | Any heart condition | ___________________ | | | | |

**Do you have any implanted devices?** Pacemaker, defibrillator, muscle stimulator, other: ___________________

**Female Patients Only:** Regular menstrual periods: □ Yes □ No History of frequent /heavy bleeding? □ Yes □ No
Type of contraception: ___________________

**Patient Signature:** ___________________ Date: __________

**Parent/Legal Representative Signature:** ___________________ Date: __________