GASTROENTEROLOGY CONSULTANTS OF LOUISVILLE

PHONE: (502) 896-4711 FAX: (502) 896-4791

Date: ________________________

Dear: __________________________________

Your physician has requested that you undergo an EGD. Enclosed you will find the following:

- A medical history form to be completed by you.
- An education sheet and consent form to be signed by you.
- Insurance waiver form to be signed by you.
- Notice of Privacy Practices form to be signed by you.
- If your physician's office did not provide us wit a COPY of your insurance card(s) then you will need to send us a COPY of the front and back of your insurance card(s).
- Enclosed is a self addressed envelope for you to mail back all of the completed forms. Please note that the cost of postage is 59 cents.

We will schedule your EGD once we receive the above forms completely filled out and signed. Please write down any dates that you can NOT have the procedure performed. IF WE DON NOT RECEIVE YOUR COMPLETED INFORMATION WITHIN 3 MONTHS OF THE MAIL OUT DATE YOUR INFORMATION WILL BE DESTROYED.

Sincerely,

Gastroenterology Consultants of Louisville

PLEASE ALLOW THREE TO SIX WEEKS TO HEAR FROM US

Gastroenterology Consultants of Louisville, P.S.C.

Gastroenterology   Hepatology   Diagnostic and Therapeutic Endoscopy

Patient Information Form
Please Print

Race: Caucasian / African American / Hispanic / Other   Date: ________________

Name: (last) ___________________________ (first) ___________________________ (initial) ________

Social Security No: ______________________ Marital Status: ____________________ Sex: Male / Female

Date of Birth: _____________ Age: ______ Home Phone: ________________ Cell: ____________

Address: ____

Patient's Employer: _________________________________ Occupation: ___________________________

Employer's Address: ____ Business Phone No: _____________

Spouse's Name: ______________________ Spouse's Employer: ___________________________________

Spouse's Social Security No: ____________________ Business or Cell No: ____________________________

Responsible Party (if different from patient and phone number) ____

Patient relationship to the insured: self / spouse / child / other   Responsible party (address) ______________

____

Name of nearest relative (not living at same address) ____

Relationship to patient: _____________________________ Phone number: _________________________

INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE

Policy Holders Name (if not patient) ______________________ Date of Birth: ________________

Insurance CO Name & Address: ____

____

Subscribers Social Security #: _____________________ Relationship to patient: Self / Spouse / Other

Policy #: __________________________________ Group #: _________________________________

SECONDARY INSURANCE COVERAGE INFORMATION

Policy Holder's Name (if not patient) ________________________ Date of Birth: ________________

Insurance CO Name & Address: ____

Policy #: _________________________________ Group #: ___________________________

Subscriber's Social Security #: ___________________ Group or Medicaid #: _________________

Relationship to Patient: Self / Spouse / Other

Please Note: The above form must be completed in its entirety.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Gastroenterology Consultants of Louisville, P.S.C. to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date: ______________ Signature: ____

Pharmacy Name: ____________________ Referring Physician: ________________________

Phone Number: ______________________ Address & Phone #: ________________________

Address: ___________________________ ____

___________________________________ ____

GASTROENTEROLOGY CONSULTANTS OF LOUISVILLE, P.S.C.
NEW PATIENT HISTORY

HISTORY
Name: ____
Age: ____ Date of Birth: ____________ Primary Care Physician: ______________________

Past Medical History (eg: High blood pressure, diabetes, heart disease, other)
____
____
____

Previous Surgeries **Name of Surgeon**
____
____

Medications (including, Aspirin, Plavix, Coumadin, and Diabetic meds.)

Name of Medication **Dose** **Name of Medication** **Dose**
____
____
____
____

Allergies to Medicine
Name of Medication **Type of Reaction**
____
____

Are You Allergic To Latex? YES or NO **Do you have a defibrillator or pacemaker? Yes or No? If so what type**____

Have you had a Sigmoidoscopy in the past? Yes / NO (if yes, when) __________________

Have you had a Colonoscopy in the past? Yes / No (if so, when) _____________________
What was found (eg? Polyps) ____

Family History: Do you have family members with colon cancer? **YES / NO**
If yes, who and the age of diagnosis? ____

Do you have family members with colon polyps? **YES / NO**
If yes, who and age at diagnosis. ____

Any family members with other cancers (uterus, ovary, other) **YES / NO**
If yes, who and what age at diagnosis. ____

Do you have Liver disease? ____

Do you have Ulcerative Colitis / Crohns disease? _________________________________

Other? ____

REVIEW OF SYSTEMS: Do you currently have any of the following symptoms?
(check YES or NO to accurately describe your symptoms.)

CONSTITUTION
WEIGHT GAIN ☐ YES ☐ NO
UNINTENTIONAL WEIGHT LOSS ☐ YES ☐ NO
FEVER ☐ YES ☐ NO
FATIGUE ☐ YES ☐ NO
WEAKNESS ☐ YES ☐ NO
OTHER_______________

EARS
HEARING LOSS ☐ YES ☐ NO
RINGING IN EARS ☐ YES ☐ NO
OTHER_______________

MOUTH
ULCERS ☐ YES ☐ NO
SORES ☐ YES ☐ NO
OTHER_______________

NOSE
SINUS TROUBLE ☐ YES ☐ NO
NOSE BLEEDS ☐ YES ☐ NO
OTHER_______________

THROAT
SORE THROAT ☐ YES ☐ NO
OTHER_______________

EYES
BLURRED VISION ☐ YES ☐ NO
LOSS OF SIGHT ☐ YES ☐ NO
OTHER_______________

GASTROINTESTINAL
DIFFICULTY SWALLOWING ☐ YES ☐ NO
HEARTBURN ☐ YES ☐ NO
HIATAL HERNIA ☐ YES ☐ NO

GASTROINTESTINAL (continued)
INDIGESTION ☐ YES ☐ NO
NAUSEA ☐ YES ☐ NO
VOMITING ☐ YES ☐ NO
BLACK TARRY STOOLS ☐ YES ☐ NO
ABDOMINAL PAIN ☐ YES ☐ NO
BELCHING/GASEOUSNESS ☐ YES ☐ NO
BLOATING ☐ YES ☐ NO
CONSTIPATION ☐ YES ☐ NO
DIARRHEA ☐ YES ☐ NO
FREQUENT LAXATIVE USE ☐ YES ☐ NO
HEMORRHOIDS ☐ YES ☐ NO
RECTAL BLEEDING ☐ YES ☐ NO
HEPATITIS ☐ YES ☐ NO
LIVER DISEASE ☐ YES ☐ NO
JAUNDICE (YELLOW EYES OR SKIN) ☐ YES ☐ NO
GALLSTONES ☐ YES ☐ NO
INGUINAL HERNIA ☐ YES ☐ NO
OTHER_______________

HEART
ANKLE SWELLING ☐ YES ☐ NO
ARTIFICIAL VALVE ☐ YES ☐ NO
CHEST PAIN ☐ YES ☐ NO
HEART MURMURS ☐ YES ☐ NO
HIGH BLOOD PRESSURE ☐ YES ☐ NO
HISTORY OF HEART ATTACK ☐ YES ☐ NO
MITRAL VALVE PROLAPSE ☐ YES ☐ NO
PACEMAKER ☐ YES ☐ NO
PALPITATIONS ☐ YES ☐ NO
OTHER_______________

LUNGS
ASTHMA ☐ YES ☐ NO
COUGH ☐ YES ☐ NO
SHORTNESS OF BREATH ☐ YES ☐ NO
EMPHYSEMA ☐ YES ☐ NO
WHEEZING ☐ YES ☐ NO
OTHER_______________

REVIEW OF SYSTEMS (continued) DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? (check YES or NO to accurately describe your symptoms.)

GYNECOLOGY (if applicable)
LAST MENSTRUAL PERIOD____________________
POST MENOPAUSAL ☐ YES ☐ NO
UTERINE CANCER ☐ YES ☐ NO
CERVICAL CANCER ☐ YES ☐ NO
OTHER_______________________________________

URINARY
BLOOD IN URINE ☐ YES ☐ NO
FREQUENT URINARY TRACT INFECTIONS ☐ YES ☐ NO
KIDNEY STONES ☐ YES ☐ NO

INFECTIOUS DISEASE
HAVE YOU HAD TUBERCULOSIS ☐ YES ☐ NO
HAVE YOU HAD HISTOPLASMOSIS ☐ YES ☐ NO

MUSCULOSKELETAL
ARTHRITIS ☐ YES ☐ NO
BACK PAIN ☐ YES ☐ NO
JOINT PAIN ☐ YES ☐ NO
OTHER_______________________________________

SKIN
RASH ☐ YES ☐ NO
ITCHING ☐ YES ☐ NO
OTHER_______________________________________

NEUROLOGICAL
DIZZINESS ☐ YES ☐ NO
SEIZURE DISORDER ☐ YES ☐ NO
EPILEPSY ☐ YES ☐ NO
OTHER__________________________________

PSYCHIATRIC
ANXIETY ☐ YES ☐ NO
DEPRESSION ☐ YES ☐ NO
TROUBLE SLEEPING ☐ YES ☐ NO
OTHER__________________________________

ENDOCRINE
DIABETES ☐ YES ☐ NO
THYROID DISEASE ☐ YES ☐ NO
OTHER__________________________________

HEMATOLOGIC/LYMPHATIC
ABNORMAL POST SURGICAL BLEEDING ☐ YES ☐ NO
ANEMIA ☐ YES ☐ NO
EASY BRUISING/BLEEDING ☐ YES ☐ NO
OTHER__________________________________

ALLERGIC/IMMUNOLOGIC
ALLERGIES (NON MEDS) ☐ YES ☐ NO
FREQUENT INFECTIONS ☐ YES ☐ NO
HIV / AIDS ☐ YES ☐ NO
OTHER__________________________________

ARE YOUR OUTSIDE MEDICAL RECORDS AVAILABLE (check YES or NO) **RECORDS REQUESTED?**

1) PHYSICIAN NAME & PHONE #____ ☐ YES ☐ NO

____ ☐ YES ☐ NO

____

2) HOSPITAL NAME____

____ ☐ YES ☐ NO

____ ☐ YES ☐ NO

3) OTHER FACILITY (eg. x-rays, labs, endoscopy) ______________________________ ☐ YES ☐ NO

____

____

PATIENT SIGNATURE____ DATE_______________

GCL PHYSICIAN SIGNATURE____ DATE_______________

GCL ARNP SIGNATURE____ DATE_______________

GASTROENTEROLOGY CONSULTANTS OF LOUISVILLE, P.S.C.

GASTROENTEROLOGY HEPATOLOGY DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY

7B Suburban Medical Plaza 4001 Dutchmans Lane Louisville, KY 40207
(502) 896-4711 Fax (502) 896-4791

PATIENT NAME: ______________________

DATE: ______________________

EGD (ESOPHOGOGASTRODUODENOSCOPY)
EDUCATION SHEET & CONSENT FORM

DESCRIPTION OF PROCEDURE:

An EGD is a procedure in which your doctor will examine the lining of your upper gastrointestinal tract and identify and potentially treat any abnormalities that are found. The exam is done with a flexible fiberoptic tube (scope) which is passed through your mouth into your stomach and within the first part of your small intestine. Your doctor will watch the exam on a TV screen. A needle for IV medicines will be placed in your arm prior to the procedure. Medicine will be injected through this needle that will make you sleepy and relaxed. Your blood pressure, respirations, pulse, and oxygen level will be monitored by a nurse throughout the procedure. Your doctor may spray your throat with a numbing medicine to relax your gag reflex. As you lie on your left side, a small mouthpiece will be placed between your teeth. As your doctor gently passes the scope through your mouth into your esophagus (food tube), and into your stomach and first part of the small intestine, he will be examining the lining for any abnormalities. You may experience some cramping and gas due to the air your doctor is putting in during the procedure. Please inform your doctor and nurses if there is any chance that you may be pregnant. Your doctor may take tissue samples (biopsy) by passing small instruments through the scope. Therapies/treatments may be performed during an EGD include, but are not limited to:

1. Dilatation - stretching narrowed areas by passing special instruments.
2. Hemostasis - stopping/controlling bleeding with special instruments and/or medicines.
3. Feeding tube placement - placing a special feeding tube through the stomach wall.
4. Removal of foreign objects - passing special instruments to retrieve objects.

After the procedure, you may feel drowsy and may sleep for a short time. You may feel bloated from the air inserted during the procedure. You will be encouraged to expel the air. Your doctor will discuss the findings with you and your family before you leave.

WHAT ARE THE RISKS OF THIS PROCEDURE?

The risks of an EGD include, but are not limited to bleeding which may require transfusions, perforation (puncture, tear or hole in the stomach, esophagus or duodenum) which may require surgery, and possible sedation reaction.

WHAT ARE THE BENEFITS OF THIS PROCEDURE?

The benefit of an EGD is that it is a nonsurgical procedure, which we utilize for direct visualization of upper GI tract that will allow us to obtain specimens as necessary and perform therapies as discussed above.

WHAT ARE THE ALTERNATIVES?

A possible alternative to an EGD is an upper GI series which is an upper GI X-ray where pictures of your upper GI tract are taken to check for abnormalities and is performed in the radiology department by an X-ray technologist. The barium contrast is swallowed and X-ray pictures are taken. A radiologist (a doctor who specializes in interpreting X-rays) will study and interpret you upper GI series and send a report to your doctor.

WHAT ARE THE RISKS OF THE ALTERNATIVES?

The risks of an upper GI series include, but are not limited to, the inability to detect mucosal lesions, Barrett's esophagus, and Helicobacter pylori, and also the inability to perform various therapies and treatments outlined above.

WHAT ARE THE BENEFITS OF THE ALTERNATIVES?

The benefits of an upper GI series is that it is a diagnostic test which requires no sedation with minimal risk and you are able to leave shortly after the scan has been completed.

I read, or had read to me, this education sheet.

______________ ______________________________
Date Patient/Person authorized to sign for Patient/relationship

______________ ______________________________
Date Witness signature

Gastroenterology Consultants of Louisville

Patient Responsibilities and Collection Policies

We welcome you and are grateful that you have chosen us to be your physician. For your information and convenience, we want to let you know about changes we have made to our billing policy. These changes are made to ensure we are in full compliance with Medicare and other federal rules and regulations.

We are happy to see you in our office however, due to an overwhelming volume of telephone triage calls our office has implemented a $25.00 service charge that is associated with ARNP triage calls. This is a charge to be billed directly to the patient's account and not the insurance carrier. This does not apply to simple medication refill request or scheduling appointments.

Co-payments and co-insurance are due at the time of your visit. We are not permitted by law to waive these payments; we must collect all co-payments and deductibles designated by your insurance carrier. Current fraud and abuse laws governing federal, state and third party contracts mandates that we cannot grant financial courtesy discounts without documented proof of financial hardship.

Our office will submit your claim to your insurance company. Your visit will be coded based on the information provided by you as the reason for the visit, as well as any and all diagnoses and/or procedures performed by the physician. Our office, in compliance with legal and ethical rules, submits claims based on what your insurance company covers. It is not our office's policy to resubmit/recode a claim in order for a greater insurance payment.

PATIENT RESPONSIBILTIES

It is your responsibility to give our office current and up to date information. This includes name, address and telephone changes, as well as current insurance information, social security number (required by our office policy and system, this is in order to schedule any procedures or test at the hospital and for billing purposes) and your drivers' license.

It is your responsibility to provide this office with any needed referrals from your primary care physician.

It is your responsibility to know your insurance plan's polices and guidelines. Every insurance company is different. You should know if your insurance company has a preferred lab or hospital, which are required to be used in order for your service to be covered.

It is your responsibility to contact your insurance company to verify that any physician you see in this practice is a participating physician with your specific plan.

COLLECTION POLICIES

We will collect your co-payment at the time of your visit. We will file your insurance for you. After your insurance company pays its portion, the remaining balance then becomes your responsibility. You will receive two monthly statements. If you fail to pay your bill in full or to make payment arrangements with us within twenty days after the date on the statement, your account will then be placed into our collection department. If we do not hear from you, your account will be sent to an outside collection specialist, which could adversely affect your credit. These collection accounts are subject to interest charge. For your convenience we accept Visa, Master Card and Discover.

I understand my responsibilities and agree to the responsibility to see that my account is kept current.

________________________________ ___________________________

Signature Date

GASTROENTEROLOGY CONSULTANTS OF LOUISVILLE

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name____

Patient Signature: ______________________________ Date: ______________________

Date of Birth: ________________________________

Name of person that medical information may be given to; other than your Doctors:

____

To view the Privacy Policy in full, please visit our web site at: www.gastroconsultants.net and click on Privacy Policy at the bottom of the web page. You may also call our office to request a copy be mailed to you. Our office phone number is (502) 896-4711.

Gastroenterology Consultants of Louisville
4001 Dutchmans Ln Ste 7B
Louisville, KY 40207

To facilitate your receiving any test results we can E-mail the results to you. If your Results require further discussion you will be notified by phone. If this is acceptable to you please visit our web site at gastroconsultants.net and click on the Pt Link Tab. This will take you to the secure patient portal, where you will need to create an account and this is a patient friendly process. Please make sure to keep a record of your User ID and password for later use.

E-Mail address: ____

Patient Signature: ____

Print Name & Date of Birth: ______________________________________

GASTROENTEROLOGY CONSULTANTS OF LOUISVILLE

Phone (502) 896-4711 Fax (502) 896-4791

INSURANCE WAIVER

PATIENT NAME:

DATE OF BIRTH:

INSURANCE ID NUMBER:

Dear Patient:

Your primary care physician has requested that you undergo a surveillance EGD or Colonoscopy. This procedure will be scheduled for you by our office. However, it is your responsibility to contact your insurance company if you are not sure of your benefits or deductible.

Some insurance plans do not have benefits for surveillance (preventative coverage) EGD or Colonoscopy.

This is an outpatient procedure and therefore your deductible may be applied if not already met.

PATIENT'S AGREEMENT: If my insurance company denies payment, I agree to be personally and fully responsible for payment.

X___________________________________ ____________________________

Signature of Patient **Date**

There will be a $100.00 charge for any

procedure not cancelled 3 (three) business

days prior to the procedure.

Deductibles and copays are required 5 days prior to procedure.

Our Business office will contact you to discuss payment due or you may contact them.

Thank You