

Gastroenterology Consultants of Louisville

GASTROENTEROLOGY HEPATOLOGY DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY

EDWARD C ADLER, M.D.

MARTIN D MARK, M.D.

GERARD V SICILIANO, M.D.

MITCHELL C KAPLAN, M.D.

LESLEY L CAMPBELL, M.D.

Dear Patient

Please arrive 15 minutes prior to your scheduled appointment time.

You have an appointment with our office, please complete the medical history forms and mail to our office one week prior to your appointment. You may also fax them to us at (502) 896-4791. **Failure to send in completed forms will result in the delay of your appointment.**

1. Any recent lab/blood work or copies of GI x-ray reports from your primary care physician
2. Actual GI films (e.g. upper or lower GI, Ultrasound, Barium Enema or Ct – Scans), which you may obtain from the radiology department or imaging center where you had the test.
3. A referral from your insurance company, **if one is required**. Please bring your actual insurance cards, as we will need to make a copy of them.
4. Your co-pay will be due at the time of your visit, as well as any outstanding balance on your account, this is due to insurance regulations.

Thank you

Gastroenterology Consultants of Louisville, P.S.C

7B Suburban Medical Plaza 1
4001 Dutchmans Lane
Louisville, Ky 40207

Norton Medical Plaza Ste 204
Old Brownsboro Crossing
4950 Norton Healthcare BLVD
40241

PHONE (502) 896-4711

FAX (502) 896-4791

Web site available @ gastroconsultants.net

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? _____

SOCIAL HISTORY

Marital Status? Single / Divorced / Married / Widow / Widower or Separated

Who lives with you? _____

Do you smoke? Yes No How many packs a day? _____ For how many years? _____

Do you currently drink alcohol? Yes No did you drink alcohol in the past? Yes No

How many drinks per day? _____ per week? _____ per month? _____

Current Occupation / Employer? _____

What type of work do you perform? _____

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)

1) PHYSICIAN NAME & PHONE # _____

RECORDS REQUESTED?

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
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

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 RESPONSIBILITIES

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 policies 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

If you have had any testing done that relates to the reason we are seeing you then you are responsible for making sure that we have a copy of your medical records at the time of your appointment.

There will be a \$25.00 charge for any office visit not cancelled 1 (one) business day prior to the appointment.

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

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: _____