

Mid-America Gastro-Intestinal Consultants,P.C.

Mark J. Allen, MD Perry J. Culver, MD John H. Helzberg, MD J. Edward McCullough, MD

Dear _____,

We are happy you selected our office to provide your healthcare needs.
This letter confirms your appointment on _____,
at _____ am / pm.

**PLEASE HELP US BE EFFICIENT BY ARRIVING 15 MINUTES
PRIOR TO YOUR SCHEDULED APPOINTMENT TIME.**

Please complete and bring with you the enclosed health history and patient information sheets. Should you have medical records related to this consultation, we ask that you obtain and bring them with you for evaluation.

Your account with our office will be on a self-pay basis if insurance information is not provided at the time of registration. It is important that you bring your insurance cards at the time of your visit.

**OUR OFFICE REQUIRES 72 HOURS NOTICE FOR CANCELLATIONS DUE
TO THE TIME WE ALLOW FOR YOUR APPOINTMENTS.**

We look forward to seeing you.

Thank you,

-For Office Use Only-

Doctor _____ Date _____

NP _____ Update _____

MAGIC _____ GI _____

Patient Account # _____

Patient Information Sheet

Last Name

First Name

Middle Name

Street Address

City

State

Zip

County

(____)____-____
Home Phone Number

____/____/____
Date of Birth

Age

____-____-____
Social Security #

Male / Female

(____)____-____
Cell Phone Number

Race: []White []Black []American Indian []Hispanic []Asian []Other

E-Mail Address _____

Employer's Name _____ Business Phone (____) ____-____ x____

Spouse's Name _____ D.O.B. ____/____/____ SS# ____-____-____

Spouse's Employer _____ Business Phone (____) ____-____ x____

Referring/Primary Physician _____

Emergency Contact (not in household) _____ Phone #(____) ____-____

Insurance Information

Primary Insurance

Secondary Insurance

Ins. Co. _____

Ins. Co. _____

Card Holder's Name _____

Card Holder's Name _____

ID# _____ Group# _____

ID# _____ Group# _____

Assignment of Benefits: I hereby assign payment directly to the physician of benefits due me for his services rendered. I understand that I am financially responsible for charges not covered by this authorization.

Patient Signature _____ **Date** _____

Medicare Lifetime Consent:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mid-America Gastro-Intestinal Consultants/GI Diagnostics for any services furnished to me. I authorize any holder of medical Information about me to release to the Health Care Financing Administration and it's agents, any information Needed to determine these benefits or the benefits payable for related services.

Patient's Signature

____/____/____
Date Signed

**Mid-America Gastro-Intestinal
Consultants, P.C.**

Personal Representative Form

By completing this form you are informing Mid-America Gastro-Intestinal Consultants that you have designated the named person(s) as your personal representative(s).

I, _____(print your name) designate the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/or disclosure of my health information.

Print name(s) of Personal Representative(s)

_____ There are no restrictions for this representative.

OR

The authority of this person when acting as my personal representative is restricted to the following functions:

_____ Medical Information

_____ Financial Information

_____ Restricted to the following: _____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Mid-America Gastro-Intestinal Consultants. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

Signature

Date

Patient identity authenticated by: _____ (office use only)

REVOCACTION SECTION:

I hereby revoke this designation of a personal representative.

Signature

Date

Patient Name _____

Date _____

Medication or Supplement	Amount Taken (Dose)	How Often (Frequency)	How Taken (Route)
e.g. Aspirin	e.g. 81 mgs	e.g. Once a day	e.g. By Mouth

ALLERGIES / REACTIONS

INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions and bring this with you to your appointment.

Patient Name: _____ Today's Date: _____
Date of Birth _____ Age _____ Place of Birth _____ Marital Status _____
Education (highest level attained) _____ Occupation _____

Please circle all illnesses or conditions you have had:

Asthma	Bleeding tendencies	Colitis	Glaucoma	High Blood Pressure	Kidney disease
Diabetes	Diverticulosis	Stroke	Heart trouble	Rheumatic fever	Tuberculosis
Cancer	Colon Polyps	Hepatitis	Jaundice	Pneumonia	Nervous disorder

Other: _____

Previous surgeries: (List newest to oldest)

<u>Type of surgery</u>	<u>Date</u>	<u>Name of Hospital</u>	<u>Name of Surgeon</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<u>Other Hospitalizations:</u>	<u>Reason</u>	<u>Date</u>	<u>Name of Hospital</u>	<u>Name of Physician</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you use tobacco now? _____ How long? _____ In the past? _____ Date quit: _____
Type of tobacco and daily amount used: _____
Do you drink alcoholic beverages? _____ In the past? _____ Type: _____ Weekly amount: _____

	<u>Living?</u>	<u>age or age @ death</u>	<u>Present health or cause of death</u>
Father	Yes ___ No ___	_____	_____
Mother	Yes ___ No ___	_____	_____
Children	Yes ___ No ___	_____	_____

Family History: (Check all that apply to blood relatives and state relationship)

____ Colon Cancer _____
____ Colon Polyps _____
____ Breast Cancer _____
____ Bleeding tendency _____
____ Heart Disease _____
____ High Blood Pressure _____
____ Kidney Disease _____
____ Liver Disease _____
____ Stroke _____
____ Any of the following Cancers: _____ Ovarian _____ Uterine _____ Prostate _____ Gallbladder
____ Stomach _____ Esophagus _____ Brain _____ Small Bowel _____ Urinary Tract

What is your main GI problem and how long have you had it? _____

Physician's Signature _____ **Date** ____/____/____

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Sandra A. Hoover, APRN, BC

Name: _____ Date: _____

Review of Systems

(check all that apply)

General (constitution/endocrine/heme)

___ chronic fatigue ___ anemia
___ weight loss
(amount____, since when?____)
___ bruise easily/bleed too long
___ diabetes ___ thyroid disease
___ fever

Gastrointestinal

___ diarrhea ___ constipation
___ heartburn ___ stomach cramps
___ nausea ___ vomiting
___ gas ___ bloating
___ liver disease ___ hoarseness
___ abdominal pain ___ blood in stool
___ trouble swallowing

Ears, Eyes, Nose, & Throat

___ ringing in ears ___ sinus trouble
___ ear infections ___ hoarseness
___ hard of hearing ___ poor vision
___ eye infections ___ cataracts
___ glaucoma

Urinary

___ urine infections ___ blood in urine
___ kidney stones ___ painful urination
___ decrease in urine force or flow

Lungs

___ cough ___ asthma
___ pneumonia ___ bronchitis
___ short of breath ___ tuberculosis

Bones & Joints

___ arthritis/rheumatism
___ back pain (chronic/recurrent)
___ osteoporosis ___ gout
___ joint pain

Heart

___ chest pain ___ palpitations
___ high blood pressure ___ ankle swelling
___ irregular hear beat ___ blood clots

Neurologic/Psychiatric

___ stroke ___ dizzy spells
___ tremor/hands shaking ___ sleep apnea
___ numbness/tingling ___ difficulty sleeping
___ headaches (frequent) ___ memory loss
___ migraines ___ seizures
___ depression ___ anxiety
___ panic attacks ___ nervousness

Skin

___ rashes ___ hives
___ allergic reactions ___ itching

<u>New Visit/Consult/Established</u>	<u>Document</u>
Expanded Problem Focused (99202/99242/99212)	1
Detailed (99203/99243/99213)	2 – 9
Comprehensive (99204/99244/ 99214) (99205/99245/99215)	10

Data Reviewed/Updated

FINANCIAL POLICY

Thank you for choosing Mid-America Gastro-Intestinal Consultants and G. I. Diagnostics for your health care needs. It is our goal to make the financial aspects of your health care as convenient and efficient as possible. Please read the following billing policies to understand your financial responsibilities as a patient.

INSURANCE AND PAYMENT POLICY

We are participating providers with Medicare and most major insurance plans. The patient should know if the physician and, if applicable, the facility where the procedure will be performed participates with your insurance plan. If your insurance plan is an HMO or EPO and requires a referral form from your primary care physician, it is your responsibility to obtain prior to your appointment. It is important for you to know your out-of-pocket costs not covered by your insurance which include deductibles, co-payments, co-insurance and non-covered services. You will be responsible for payment in full of any balance on your account upon receipt of your Explanation of Benefits from your insurance company or a balance due statement from our office. Co-pays are due at the time of service.

PAYMENT METHODS

We accept payment by cash, check or money order, VISA, MasterCard or Discover. There will be a \$25.00 service charge on all returned checks.

SELF-PAY PATIENTS

Patients will be required to pay in full the estimated charges prior to procedures being performed. Office visits are to be paid in full at the time of service.

BALANCE DUE STATEMENTS

You will receive an itemized statement on any outstanding balance on your account. Statements are mailed monthly. The balance should be paid in full unless financial arrangements have been made with our business office. Past due accounts will be reviewed for possible collection proceedings.

PROCEDURE APPOINTMENTS – CANCELLATIONS/RESCHEDULED

We make every effort to accommodate your scheduling needs. It is important to be on time for your procedure, arriving early as requested, and to notify us in the event you need to reschedule your appointment. We reserve for our patients, the amount of time we need to provide quality health care. Therefore, sufficient notice to change your procedure appointment is necessary in order to offer this time to another patient.

We require a minimum of three (3) business days prior to your scheduled procedure appointment for any cancellation or rescheduling needs.

PROCEDURE APPOINTMENTS CANCELLED/RESCHEDULED WITHOUT SUFFICIENT NOTICE (3 BUSINESS DAYS) WILL INCUR A CHARGE OF \$ 100. THIS CHARGE IS NOT COVERED OR PAID BY ANY INSURANCE COMPANY; THEREFORE THE CHARGE WILL BE BILLED DIRECTLY TO THE PATIENT.

DEDUCTIBLES

The business office will contact you once benefits have been verified with your insurance plan. Deductible amounts are the responsibility of the patient. Advance payment is required on procedure appointments.

PRE-CERTIFICATION

We will contact your insurance company to obtain pre-certification on procedures scheduled by our office. Pre-certification does not guarantee coverage and/or payment by your insurance plan. It is your responsibility to know the extent of coverage for services provided by our office.

PROCEDURE BILLINGS

If your procedure is done in our endoscopy center, you will receive two bills; one for the physician's professional services and the other for facility fees. The professional fee is billed by Mid-America Gastro-Intestinal Consultants and reflects the services provided by the physician. The facility fee is billed by G. I. Diagnostics.

You may receive a statement from Plaza Anesthesia. This company bills for anesthesia services provided during your procedure.

Any pathology performed during your procedure will be billed by the entity providing the service.

SCREENING VS. DIAGNOSTIC COVERAGE

Insurance companies often provide screening benefits for routine screening colonoscopy. However, if during your screening procedure the physician removes a polyp or performs biopsy, the procedure may be considered diagnostic and may not be covered as a screening exam. In this case, some insurance companies drop financial responsibility to the patient for all or part of the procedure cost. It is important for you to know if this may apply to your routine screening benefits.

I have read, understand and accept the above financial policies.

Patient's Name

Date