-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

(_____) ____-______ ____/____/____ ______ _____-____-_____ Male / Female
Home Phone Number Date of Birth Age Social Security #

(_____) ____-______
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)

REVOCATION SECTION:

I hereby revoke this designation of a personal representative.

____ ____________________

Signature **Date**

Patient Name ______________________ Date __________

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

ALLERGIES / REACTIONS

PRE SEDATION MEDICAL HISTORY

PATIENT NAME: ___________________________________ DATE: ________________ AGE: ________

Last First

Sex: ______ Ht: ______ Wt: _______ **CIRCLE: Y-YES N- NO**

HISTORY OF DISEASE: Have you ever been told that you have had any of the following conditions?

PULMONARY

- Y N Asthma
- Y N ED for Asthma
- Y N Rescue Inhaler
- Y N Emphysema/COPD
- Y N Bronchitis
- Y N Chronic Cough
- Y N Tuberculosis
- Y N Pneumonia
- Y N Shortness of breathe
- Y N Smoking History
  Pks/day ___ & ___ Yrs
- Y N Quit? ______ when
- Y N Use Oxygen
- Y N Sinus problems
- Y N Seasonal Allergies
- Y N Snore at night
- Y N Sleep Apnea (OSA)
- Y N CPAP Machine
- Y N Normal exercise tolerance

MUSCULOSKELETAL

- Y N Arthritis
- Y N Rheumatoid Arthritis
- Y N Stiff Neck
- Y N Diff Lying Flat
- Y N Fibromyalagia
- Y N Osteoporosis
- Y N Chronic fatigue syn
- Y N Lupus

CARDIOVASCULAR

- Y N High blood pressure
  Years: ________
- Y N Low blood Pressure
- Y N Heart attack / MI
  Years: ________
- Y N Artery Disease
- Y N Heart Stents/Angioplasty
- Y N Open Heart Surgery
  Date: ________
- Y N Chest Pain/ Angina
  Date: ________
- Y N Heart Murmur
- Y N Cardiomyopathy
- Y N Blood Clots
- Y N Heart Failure
- Y N Pacemaker
  MODEL _______
- Y N Internal Defibrillator
- Y N Bleeding Tendency
- Y N Blood Transfusion
- Y N Bruise Easily
- Y N Heart Valve Surgery
- Y N Valve regurgitation

ENDOCRINE

- Y N Low Blood Sugar
- Y N Diabetes:_______ yrs
- Y N Take Insulin
- Y N Thyroid
- Y N Weight gain/ loss

LIVER

- Y N Drink Alcohol (now)
  Daily __ Weekly __
  Monthly___ Rare ___
- Y N Heavy Drinker
- Y N Cholesterol
- Y N Hepatitis
- Y N HIV / AIDS
- Y N Yellow Jaundice
- Y N Cirrhosis

GASTROINTESTINAL

- Y N Constipation
- Y N Diarrhea
- Y N Irritable Bowel
- Y N Stomach Ulcers
- Y N Indigestion
- Y N Crohns
- Y N Bleeding/Ulcer
- Y N Reflux/ GERD
- Y N Colon Polyps
- Y N Colitis
- Y N Barrett's
- Y N Difficulty Swallowing

RENAL KIDNEY

- Y N Kidney Disease
- Y N kidney Stones
- Y N Bladder Infections
- Y N Prostate Problems
- Y N Incontinence

NEUROLOGICAL

- Y N Migraines
- Y N Stroke
- Y N TIA-mini stroke
- Y N Parkinson's
- Y N Seizures
- Y N Blackouts
- Y N Memory Problems
- Y N Alzheimer's
- Y N Depression

MISCELLANEOUS

- Y N Claustrophobia
- Y N Hard of Hearing
- Y N Wear Hearing Aid
- Y N Hospitalizations
- Y N Cancer____Where
- Y N Reactions to local or General Anesthesia
- Y N Family History of Anesthesia Problems
- Y N Partial Plate
- Y N Dentures
  Upper / Lower
- Y N Food Allergies
- Y N Latex Allergy

ARE YOU TAKING

- Y N Aspirin
- Y N Blood thinners
- Y N Herbal supplements
- Y N Steroids / Prednisone

PREVIOUS SURGERIES / LIST	
	Y N Colonoscopy
	when:
	Y N EGD (food tube)

Plaza Anesthesia, P.C.

Sedation for your procedure will be provided by a CRNA or Specialized Anesthesia Provider. We will bill your insurance company for this service. You may receive an explanation of benefits from your insurance company stating we are an out-of-network provider. All charges where services were administered in G.I. Diagnostics, Inc. will be processed on an in-network level. The patient will only be responsible for any balance due when paid to a participating provider.

Any questions, please contact the billing office at (816) 561-8151 and an account representative will be happy to assist you.

G.I. DIAGNOSTICS, INC./ PLAZA ANESTHESTHESIA SERVICES
Consent Form

Patient Name__________________________________ Date:____/____/______

Age________ Time_____________

Consent for: Esophagogastroduodenoscopy (EGD)
Colonoscopy
Flexible Sigmoidoscopy
Sedation Anesthesia

I understand that the doctor is going to insert a flexible tube (scope) with a camera at the tip into my stomach and/or bowel to look for abnormalities. If there are abnormalities such as polyps or bleeding sites the doctor will remove the polyps(s) or cauterize the areas as needed. I understand that intravenous sedation may be given to me for this.

The following risks and complications have been explained to me and all of my questions have been answered to my satisfaction. These risks include:

1. Perforation (or tear) in the esophagus, stomach or bowel requiring surgical repair.
2. Bleeding following polyp removal, which can occur days later.
3. Extremely rare complications such as reuture of the spleen or liver and death have been reported.
4. There is a possibility that I may require hospitalization, surgery or a blood transfusion because of the complications that may arise.
5. Adverse reactions can occur from the preparation prior to colonoscopy including dehydration and electrolyte imbalance causing low blood pressure and heart irregularity.
6. Endoscopic procedures are not perfect and there is still a possibility that some abnormalities, even malignancies could be missed. Alternative assessment, including other imaging studies are available but may not be as effective.
7. All forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure. Although rare, unexpected severe complications of anesthesia can occur including the unlikely possibility of infection, bleeding, drug reactions, changes in blood pressure, blood clots, loss of sensation, paralysis, stroke, heart attack or death. Some, but not all of the common risks are nausea, vein irritation and swelling or bruising at the IV site. If the placement of an airway devise in the mouth or nose is needed to maintain an open airway, this may cause dental or nose damage or laceration of the lips or gums.

Summary:

The advantages, disadvantages, risks and possible complications of my procedure(s) and associated anesthesia have been explained to me. Although it is impossible for me to be informed of every possible complication that can occur, I have had all of my questions answered to my satisfaction. In signing the consent for my procedure(s) and anesthesia, I am stating that I have read the informed consent (or it has been read to me) and I fully understand it and the possible risks and benefits that can result from the procedure(s) and associated anesthesia.

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