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

4321 Washington Medical Plaza III,
Suite 5600 Kansas City, MO 64111

(O) 816-561-2000
(F) 816-931-7559

## Patient Interview Form

### Patient Information

First Name:__________ MI:____ Last Name:__________

Age:__________ Date Of Birth:__________

**Gender**

- ◯ Male
- ◯ Female
- ◯ Other

**Race**

- ◯ White/Caucasian
- ◯ Black or African American
- ◯ Asian
- ◯ Hispanic or Latino
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Mixed
- ◯ Other
- ◯ Unknown
- ◯ Patient declines to provide information

**Preferred Language**

- ◯ English
- ◯ Spanish
- Other:__________

### Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies

Other:__________ Other:__________ Other:__________ Other:__________

### Current Medications

◯ None

| Name | Dose | How taken? |
|---|---|---|
| | | |
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## Past or Present Medical Conditions

- None

**Pulmonary**
- Asthma
- Bronchitis/Chronic
- COPD
- Emphysema
- Pulmonary Embolism
- Seasonal Allergies
- Sleep apnea/C-pap
- Sleep apnea/No C-Pap
- TB exposure/Treated
- Other: ______

**Muscle/Skeletal**
- Arthritis
- Back Pain (chronic)
- Fibromyalgia
- Gout
- Joint Pain
- Osteoarthritis
- Osteopenia
- Osteoporosis
- Other: ______

**Cardiovascular**
- Angina/Chest Pain
- Aortic Stenosis
- Atrial Fibrilation
- Congestive Heart Failure
- Coronary Heart Disease
- Defibrillator
- Endocarditis
- High blood pressure
- High Cholesterol
- MI/Heart Attack
- Pacemaker
- Rheumatic Fever
- Other: ______

**Endocrinology**
- Diabetes Mellitus
- Thyroid Disease-Hypo
- Thyroid Disease-Hyper
- Other: ______

**Eyes**
- Glaucoma
- Cataracts
- Macular Degeneration
- Other: ______

**Gastrointestinal**
- Barrett's Esophagus
- Celiac Disease
- C-diff infection, h/o
- Cirrhosis
- Colon Polyps
- Crohn's Disease
- Diverticulosis
- Diverticulitis
- Elevated Liver Function Tests
- Fatty Liver Disease
- Gallstones
- Gastric Polyps
- Gastric Ulcer
- Gastroparesis
- GERD/Reflux
- GI Bleed
- Hiatal Hernia
- Hemorrhoids
- Hepatitis B
- Hepatitis C
- IBS
- Obesity
- Other Liver Disease
- Pancreatitis
- Ulcerative Colitis
- Other: ______

**Neurology**
- Alzheimer's Dementia
- Memory Loss
- Migraine Headaches
- Neuropathy
- Seizure disorder
- Stroke
- TIA
- Other: ______

**Psychiatric**
- Alcohol Abuse
- Anxiety
- Bipolar Disorder
- Depression
- Panic Attacks
- PTSD
- Substance Abuse
- Other: ______

**Cancer**
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Esophageal Cancer
- Liver Cancer
- Lung Cancer
- Lymphoma
- Mouth/Gums Cancer
- Ovarian Cancer
- Pancreatic Cancer
- Prostate Cancer
- Skin Cancer
- Small Bowel Cancer
- Stomach/Gastric Cancer
- Thyroid Cancer
- Uterine Cancer
- Other: ______

**Other**
- Anemia
- Bleeding Disorder
- Blood Clots/DVT
- Chronic Fatigue Syndrome
- Difficulty Sleeping
- Endometriosis
- Enlarged Prostate (BPH)
- HIV
- Renal Insufficiency
- Renal Failure
- Immune Deficiency
- Other: ______

## Previous Procedures

- None
- Appendectomy
- Back Surgery - unspecified
- Bladder Lift
- Cataract
- Cholecystectomy/ Gallbladder
- Caeserean Section
- Coronary Artery Bypass Graft (CABG)
- Colectomy - partial unspecified
- Dilation and Curettage (D and C)
- Defibrillator Placement
- Dialysis Catheter Placement
- Gastric Bypass - type unspecified
- Heart Stent
- Heart Transplant
- Heart Valve Replacement
- Hemorrhoidectomy
- Hernia Repair - site unspecified
- Hiatal Hernia Repair
- Hip Replacement
- Hysterectomy - Abdominal
- Hysterectomy Transvaginal
- Hysterectomy w/ BSO
- Knee Surgery
- Knee replacement
- Mastectomy Breast Left
- Mastectomy Breast Right
- Non-replacement Joint Surgery
- Other Joint Replacement
- Pacemaker Insertion
- Prostatectomy - Radical
- Prostate Radiation/Seeding
- Small Bowel Resection
- Tonsils and Adenoids
- Wisdom Teeth

Other: ______

## Diagnostic Studies/Tests

- ⬭ None
- ⬭ Colonoscopy — When: ______
- ⬭ Flexible Sigmoidoscopy — When: ______
- ⬭ EGD/Colonoscopy — When: ______
- ⬭ EGD — When: ______
- ⬭ Capsule Endoscopy — When: ______
- ⬭ Abdominal Ultrasound — When: ______
- ⬭ Pelvic Ultrasound — When: ______
- ⬭ CT Abdomen/Pelvis — When: ______
- ⬭ MRI Abdomen/Pelvis — When: ______
- ⬭ Procto — When: ______

## Immunizations

- ⬭ None
- ⬭ Flu vaccine — When: ______
- ⬭ Hep A, adult — When: ______
- ⬭ Hep B, adult — When: ______
- ⬭ Hep A-Hep B — When: ______
- ⬭ HPV — When: ______
- ⬭ Meningococcal — When: ______
- ⬭ Pneumovax — When: ______
- ⬭ PPD — When: ______
- ⬭ Tdap — When: ______
- ⬭ Varicella — When: ______

## Social History

Occupation: ______ Number of Children: ______

**Marital Status**

- ⬭ Single
- ⬭ Married
- ⬭ Divorced
- ⬭ Separated
- ⬭ Widowed
- ⬭ Civil Union

**Alcohol**

- ⬭ None
- ⬭ Daily
- ⬭ Weekly
- ⬭ Monthly
- ⬭ Rarely
- ⬭ 7 or less per week
- ⬭ More than 7 per week
- ⬭ Recovering Alcoholic

**Tobacco**

**Smoking Status**

- ⬭ Current every day smoker
- ⬭ Current some day smoker
- ⬭ Former smoker
- ⬭ Never smoker
- ⬭ Smoker, current status unknown
- ⬭ Unknown if ever smoked
- ⬭ Cigarettes
- ⬭ Cigar
- ⬭ Chewing Tobacco
- ⬭ Pipe

**Drug Use**

- ⬭ None
- ⬭ Never
- ⬭ Uses IV drugs currently
- ⬭ Used IV drugs in the past
- ⬭ Recreational drug use

**Exercise**

- ⬭ None
- ⬭ 1-3 times weekly
- ⬭ More than 3 times weekly
- ⬭ Walk
- ⬭ Jog/Run
- ⬭ Weights
- ⬭ Other

**Caffeine**

- ⬭ None
- ⬭ 1-2 per day
- ⬭ 3-4 per day
- ⬭ more than 5 per day

## Family Medical History

○ No knowledge of family history

| Diagnoses | Mother | Father | Sister | Brother | Daughter | Son | Maternal Grandmother | Paternal Grandmother | Maternal Grandfather | Paternal Grandfather | Maternal Aunt | Paternal Aunt | Maternal Uncle | Paternal Uncle | First Cousin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Barrett's Esophagus | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Breast cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Celiac Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Crohn's Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Dementia | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Diabetes | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Esophagus Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Gallbladder Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Heart Disease/Heart Attack | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Hypertension | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| High Cholesterol | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Kidney Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Liver Cancer/Liver Disease/Cirrhosis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Ovarian Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Pancreatic Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Prostate Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Small Bowel Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Stomach Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Stroke/TIA | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Ulcerative colitis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Uterine Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Other: | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Mid-America Gastro-Intestinal Consultants P.C.**
**Saint Lukes GI Diagnostics LLC**
**Plaza Anesthesia P.C.**

## Authorization for Disclosure of Health Information

**Patient Name:**______________________________ **Date of Birth:**______________

*I authorize the use or disclosure of the above named individual's health information as described below.*
*The following individual or organization is authorized to make the disclosure:*

Name: Mid-America Gastro-Intestinal Consultants, PC / Saint Lukes GI Diagnostics, LLC / Plaza Anesthesia, PC
Address: 4321 Washington
Kansas City, MO 64111

In order to protect your confidentiality and to comply the government regulations (HIPAA), the above organizations are required to obtain authorization from you in order to leave messages and/or provide information regarding your care.

I give my consent to the physicians and staff to leave messages or discuss appointments/scheduling, treatment, surgery, lab, radiology results, financial or other information regarding my care as follows:

a) On answering machine or voice mail on **home phone**?
___ **YES:** (If yes: __ Brief/ __ Detailed message) ___ **NO**

b) On answering machine or voice mail on **work phone**?
___ **YES:** (If yes: __ Brief/ __ Detailed message) ___ **NO**

c) On answering machine or voice mail on **cell phone**?
___ **YES:** (If yes: __ Brief/ __ Detailed message) ___ **NO**

d) May we send emails to your provided **email address**?
___ **YES:** (If yes: __ Brief/ __ Detailed message) ___ **NO**

e) **Spouse or legal representative:**
Name: ______________________ Relationship: ____________ Phone: ____________
Name: ______________________ Relationship: ____________ Phone: ____________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand this authorization will expire in one (1) year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: (816) 561-2000.

______________________________ ______________________________
Signature of patient or legal representative Signature of Witness

Date: ______________________ Date: ______________________

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by the state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243) and federal law 42 CFR, part II.

SEE OTHER SIDE →

# FINANCIAL POLICY & DISCLOSURE

Thank you for choosing Mid-America Gastro-Intestinal Consultants and Saint Luke's - G. I. Diagnostics, LLC 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 $35.00 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 Saint Luke's - G. I. Diagnostics, LLC.

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.

**OWNERSHIP**
Saint Lukes - GI Diagnostics, LLC is majority owned by Saint Luke's Hospital, in part with physicians of Mid-America Gastro-Intestinal Consultants. Plaza Anesthesia is currently owned and operated by physicians of Mid-America Gastro-Intestinal Consultants. If you are concerned about your referral to the center, arrangements can be made to schedule your evaluation at an alternative site.

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

______________________________ ________________

Patient's Name Date