Patient Packet

Please print this pdf and fill out the following forms. Please bring these forms with you when you arrive for your appointment.

- Patient Information Form
- Medical Consent Form
- Patient Health History
- Midlands Gastro Financial Policy
- Practice Policies
- Notice of Privacy Practices
- Acknowledgement of Receipt of Notice of Privacy Practices

Midlands Gastroenterology
One Wellness Blvd. Suite 110 Irmo, SC 29063-2872 (803)732-8632
Monday - Thursday 8am to 4:30pm, Friday 8am to 12noon

Patient Information

Name:

Social Security Number (SSN) and Date of Birth:

Home Address:

City - State - Zip:

Mailing Address (if different):

City - State - Zip:

Home Phone:

Work Phone:

Email Address:

Sex: ☐ M ☐ F

Status: Single | Married | Widowed | Divorced | Separated

☐ ☐ ☐ ☐ ☐

Referring Physician's Name & Address:

Spouses Name:

Healthcare Proxy: ☐ Y es ☐ No

Employment Information

Employer (Parents employer if minor):

Occupation

Employer Address:

Phone:

Spouse's Employer:

Spouse's Date of Birth | Spouse's SSN

Spouse's Employer Address:

Spouse's Phone

Responsible Party Information

Person Responsible For Medical Expenses: (if not patient)

Relationship To Patient | Phone Number

Home Address:

City - State - Zip:

Primary Insurance Information

Insurance Company:

Policy Number | Medicare Number | Medicaid Number

Subscribers Name:

Subscriber's Relationship to Patient: Self | Spouse | Parent | Other:

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Address Of Insurance Company

Secondary Insurance Information

Insurance Company:

Policy Number | Medicare Number | Medicaid Number

Subscribers Name:

Subscriber's Relationship to Patient: Self | Spouse | Parent | Other:

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Address Of Insurance Company

Emergency Information

Person To Contact In Case Of An Emergency: (Not Spouse)

Relationship To Patient | Phone Number

Home Address:

City - State - Zip:

Authorization

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient's Signature & Date

Responsible Party Signature & Date

Midlands Gastroenterology, PC
One Wellness Blvd., Suite 110
Irmo SC 29063

MEDICAL CONSENTS

NAME:_____ DATE_____

ADDRESS:_____

Ethnicity:_____ Race:_____ Nationality:_____

Pharmacy:_____ Street & City Location_____

MEDICATION CONSENT: Medication consent is requested as an integral part of your health care. With today's technology it affords your physician the opportunity, through your insurance company and pharmacy, to cross check your medications list. This is an important tool in that it adds an extra step in protecting the patient against adverse reactions, etc from taking more than one medication. Ex: patient may have several physicians all prescribing different medications that could possibly have adverse reactions when mixed.

PATIENT REFERRAL CONSENT: Patient referral consent is requested because at times it is necessary for your physician to refer you to another physician for continuation of care, ie: should you need to see a surgeon or another specialist for further treatment, tests and evaluation. The consent allows us to send the referral request electronically as well as verbally by phone.

COMMUNITY EXCHANGE: Community exchange consent is requested because it affords the physician the ability to electronically exchange health information. Technology is growing by leaps and bounds and it is exciting to know that physicians can be interconnected. Let's suppose a patient was seen in the emergency room and was referred to our office for a follow-up for the next day. Our physician would be able to electronically pull up the patient's record of that visit and any labs that may have been done. This saves hours and sometimes days in trying to retrieve important information necessary to evaluate and treat a patient.

By signing below you acknowledge that you have read, understand and agree to the above consents.

Patient Name:_____Signature:_____

Responsible Party(if pt is minor or unable to sign for themselves):
Name:_____Signature:_____

Midlands Gastroenterology, PC

PATIENT HEALTH HISTORY

NAME:_____ **DATE:**_____
SSN:_____ **DOB:**_____
Referring Physician:_____

I. CHIEF COMPLAINT: What is the reason for your visit today? _____
Describe:_____

Have you previously had an endoscopy or colonoscopy? _____ If so, where?_____

II. PAST MEDICAL HISTORY: Please check all that apply to you.

___ High Blood Pressure	___Diabetes	___Heart Disease	___ Lung Disease
___ Kidney Disease	___ Gallstones	___ Peptic Ulcer	___ Thyroid Disease
___ Acid Reflux	___ Pancreatitis	___ Hemorrhoids	___ Anemia
___ Colon Cancer	___ Colon Polyps	___ Other cancers	___ Rheumatic fever
___ Joint Replacements	___ Psychiatric Illness	___ Blood Transfusion	___ Bleeding Problem
___ Artificial Heart Valve	___ Asthma		

If yes, please explain:_____
_____
_____

III. PAST SURGICAL HISTORY: Please list past surgeries with approximate date.

DATE	SURGERY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IV. SOCIAL HISTORY:
Do you drink alcohol? ___yes ___no If yes, how much per week?_____
Do you smoke cigarettes? ___yes ___no If Yes, how much? _____If you quit, when?____
Do you or did you use recreational drugs? ___yes ___no
If yes, what type and how often?_____

V. FAMILY HISTORY: Please check all that anyone in your immediate family has ever had.

___ COLON Cancer	___ Other Cancers	___ Peptic Ulcer
___ Liver Disease	___ Cirrhosis	___ Other Digestive Disease

VI. CURRENT MEDICATIONS: Please list all prescription and non-prescription medications you are taking.
_____
_____
_____
_____
_____

VII. DRUG ALLERGIES: _____
Other Allergies:_____

VIII. DIGESTIVE SYSTEM: Please check all that apply to you.

___ Loss of weight	___ Loss of appetite	___ Excessive fatigue
___ Increased stress	___ Frequent nausea	___ Vomiting
___ Vomiting blood	___ Difficulty swallowing	___ Frequent indigestion
___ Heartburn	___ Awaken at night w/pain	___ Abdominal pain
___ Stomach fills up fast when eating	___ Change in size, color or shape of stool	___ Blood associated with bowel movements
___ Frequent diarrhea	___ Frequent constipation	___ Black/tarry stools
___ Pain with meals	___ Jaundice	___ Do you take laxatives

___ Do you take antacids	___ Visible abdominal bloating	___ Mucus in the stool
___ Incomplete emptying of the bowels	___ Abdominal cramping prior to bowel movements	
___ Relief of pain with bowel movements	___ Abdominal pain related frequent, loose bowel movements	

Midlands Gastroenterology

FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing our practice for your gastroenterology service. Please note that payment is due when services are rendered. You are encouraged to ask any questions regarding fees with our billing office.

FEES/BILLING

Please note: If a procedure is scheduled there will be a **facility charge** from the establishment where your procedure will be performed and a **physician charge** from Midlands Gastroenterology. If a biopsy is done then **lab** would charge to process and read that biopsy.

MISSED APPOINTMENT FEE

There will be a **$25.00** fee for any missed office visit not cancelled 24 hours prior to the appointment time. There will be a **$50.00** fee for any missed endoscopic procedures not cancelled 24 hours prior to the appointment time. This is to defray extra expense incurred by our practice to reschedule you for these appointments and the unutilized time slots.

RETURNED CHECKS

There will be a **$30.00** charge for all returned checks. Please note that our practice will not redeposit your check due to the recurrent charges /fees to our practice account.

INSURANCE

Our charges are usual and customary for our area. We encourage all patients to confirm their coverage with their insurance company prior to their appointment date. Services provided by our physicians in a hospital, other facility and/or office will be filed to your insurance company, provided we are given sufficient information. **You will however, be asked to pay your deductible and/or copay at the time of service.** If we do not participate with your insurance company, we will file it as a courtesy to you and **any unpaid balance following insurance payment is your responsibility.** For those insurance companies we do participate with, **any monies due after the applicable contractural adjustment is your responsibility.** The amount of payment by your insurance company depends on your individual policy. **It is important you understand your policy and what it covers. If you are uncertain that we are a participating provider, please refer to your manual or contact your insurance company.**

NON INSURED

If you do not have medical insurance **you will be responsible for your entire bill.** If you are experiencing financial difficulty or hardship, the business office may establish a payment plan arrangement with you. **Please call prior to your visit to make this arrangement.**

INSURED AND UNINSURED – NON PAYMENT ISSUES

Unless you have a payment plan arrangement and *are abiding by the conditions therein*, all delinquent accounts will be sent to a collection agency. Once an account is turned over to a collection agency the patient is automatically discharged from this practice *AND AN ADDITIONAL $13.00 COLLECTION FEE WILL BE ADDED TO THE BALANCE.*

MEDICARE

We are a participating provider with Medicare. As an added service, if you have insurance coverage secondary to Medicare, we will also file this for you. **We do not participate with all Medicare PFFS, PPO and MCO plans. It is your responsibility to check with your insurance company regarding participation.**

MEDICAID

We are a participating provider for South Carolina Medicaid, however **you must have a current card at the time of your service. Your card must have remaining visits to be valid. Please note that WE DO NOT ACCEPT ALL MANAGED CARE/HMO MEDICAID PLANS. It is your responsibility to check with your insurance company regarding participation.**

Initial here_____

WORKERS COMPENSATION

We do not file worker's compensation. Payment is due when services are rendered.

WHEN YOUR INSURANCE CHANGES

Your insurance coverage may change from one visit to the next. **It is your responsibility to notify us of any changes in your insurance before you are seen.** Your cooperation is continuously needed when updating your information at registration.

LAB TESTING

There are variable insurance guidelines for laboratory testing. **It is your responsibility to check with your insurance company regarding any restrictions they may have as to where your testing may be done.** ***We cannot be held responsible for your testing being done at the wrong lab.***

METHOD OF PAYMENT

We accept Cash, Checks, Visa, Mastercard and Discover.

AS A COURTESY TO YOU, WE MAKE EVERY EFFORT TO VERIFY YOUR ELIGIBILITY AND BENEFITS PRIOR TO SERVICES. HOWEVER, THERE ARE VARIABLES WITHIN EACH INSURANCE COMPANY AS TO HOW THEY PAY. THE INFORMATION GIVEN TO US BY THEIR REPRESENTATIVES MAY NOT ALWAYS BE ACCURATE. THEREFORE, IT IS YOUR RESPONSIBILITY TO CHECK WITH YOUR INSURANCE COMPANY REGARDING YOUR ELIGIBILITY AND BENEFITS. PLEASE BE ADVISED THAT BY AFFIXING YOUR SIGNATURE BELOW YOU ARE ACCEPTING RESPONSIBILITY FOR TOTAL PAYMENT OR ANY PORTION NOT COVERED BY YOUR INSURANCE COMPANY.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to this financial policy. **Sign:**_____

Date:_____

Midlands Gastroenterology, PC

PRACTICE POLICIES

Thank you for selecting our practice for your gastroenterology service. We are committed to patient satisfaction and quality care. The following policies have been implemented in order to give each patient the most efficient care.

1. Please bring an updated list of all current medications to each visit.

2. Refill requests must be called to our office from 8am – 1pm Monday thru Thursday. If you call in the request after these specified times your request may not be processed until the next business day. ***Approval from the physician is required before our staff may call in your prescription. Therefore, allow ample time before running out of medications.***

3. There will be a $25.00 fee for any missed office visit not cancelled **24 hours prior** to the appointment time. There will be a $50.00 fee for any missed endoscopic procedures not cancelled **24 hours prior** to the appointment time. **This is to defray extra expense incurred by our practice to reschedule you for these appointments and the unutilized time slots.** ***You will be responsible for these charges.***

Thank you for understanding our practice policies. Please let us know if you have any questions or concerns.

I have read the above policies. I understand and agree to the practice policies for Midlands Gastroenterology, PC.

_____ _____

SIGNATURE (Patient or Responsible party) DATE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the service provided, and the medical condition being treated.

Health care operations Your health information may be used as necessary to support the day-to-day activities and management of Midlands Gastroenterology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization which will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders Your health information will be used by our staff to send you appointment reminders.

Information about treatments Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights You have certain rights under the federal privacy standards. They include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Midlands Gastroenterology Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request your records by contacting the office Administrator. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you do so by sending a letter outlining your concerns to:

Office Administrator
Midlands Gastroenterology
1 Wellness Blvd., Suite 110
Irmo, SC 29063

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Please contact the office Administrator for further information concerning our privacy practices.

Effective Date

This notice is effective on or after April 15, 2003.

Acknowledgement of Receipt of Notice of Privacy Practices

Midlands Gastroenterology reserves the right to modify privacy practices outlined in the notice.

Signatures

I have received a copy of the Notice of Privacy Practices for Midlands Gastroenterology.

Name of Patient (print)

Signature of Patient

Date

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Please list name/s of persons whom you are authorizing Midlands Gastroenterology to disclose patient's health information to and their relationship to patient.

Name	**Relationship**
Name	**Relationship**
Name	**Relationship**