Site information/Label

Site: MLGA

Address:

Consent to Treat/Assignment of Benefits

Patient Name: _____ Date of Birth: _____

I understand and agree that Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health may provide treatment to me and may use and disclose protected health information about me for treatment, payment and/or health care operations.

I authorize the release of any medical information necessary to process my claims to the insurance companies/carriers listed in my file . I authorize and assign payment of medical benefits on my behalf directly to Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health. A copy of this authorization will be as valid as the original.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

NAME:_____ D.O.B_____

Do any of the following currently apply? Please circle all that apply.

Fever / chills / fatigue / sleep disturbance / change in appetite / weight gain / weight loss / headache / mouth ulcers

Hearing impairment / ringing in the ears / sinus pain / swollen glands

Double vision / blurred vision / eye pain / history of eye inflammatory disorders

Chest pain / irregular heartbeat / fluid accumulation in the legs

Abdominal pain / heartburn / difficulty swallowing / painful swallowing / nausea / vomiting /Change in bowel habit / constipation / diarrhea / rectal bleeding / dark stools / intolerance to dairy

Heavy menstrual bleeding / menstrual bleeding between periods

Burning on urination / difficulty with urination / blood in urine

Muscle aches / painful joints / swollen joints

Hives / rash / itching / seasonal allergies / food allergies

Dizziness / fainting / memory loss / seizures

Anxiety / depressed mood / mood swings / irritability / substance abuse / are you a victim of physical or mental abuse

Do you have any drug allergies? YES / NO

If so, what medicine(s) are you allergic to and what is the reaction?

Do you use anti-inflammatory drugs (Ibuprofen, Advil, Aleve, etc.)? YES / NO – How Much? _____

Do you use? - Aspirin, Vitamin E, Coumadin (Warfarin), Plavix (Clopidogrel), Pradaxa (Davigatran), Xarelto (rivaraxaban), Pletal (Cilostazol), Effient (Prasugrel), Brilinta (Ticagrelor), Ticlid (Ticlopidine), Eliquis (Apixaban)

Please list all medications and dosages (include over the counter drugs, vitamins and supplements)

1.	**4.**	**7.**
2.	**5.**	**8.**
3.	**6.**	**9.**

Would you like a chaperone during any part of your exam? YES NO

Name: _____ Date of Birth: _____

Medical History – *Have you ever been diagnosed with any of the following? Please check all that apply.*

____Abdominal aortic aneurysm (I71.4)
____Anemia (D64.9)
____Arthritis (M19.90)
____Arthritis, Rheumatoid
____Asthma (J45.9_ _)
____Atrial Fibrillation (I48.91)
____Bladder Infection (N30.90)
____Cancer: _____
____Chemotherapy, currently
____Breast Cancer, history (Z85.3)
____Colon polyps, personal history (Z86.010)
____Colon cancer, personal history (Z85.038)
____Celiac Disease (K90.0)
____Cirrhosis (K74.60)
____Coronary Artery Disease (I25.10)
____Crohn's Disease (K50.90)
____Diabetes (E11.9)
____Diverticulosis (K57.90)
____Elevated Cholesterol (E78.0)
____Emphysema (J43.9)
____Endocarditis (Infected Heart Valve) (I38)
____Endometriosis (N80.9)
____Fibromyalgia (M79.7)
____Gallstones (K80.20)
____Gastritis (K29.70)
____GERD – Gastroesophageal Reflux (K21)
____Glaucoma (H40.9)
____Heart Attack (I21.3)
____Hemorrhoids (K64.9)
____Hepatitis (K75.9)
____Hepatitis B (B19.10)
____Hepatitis C (B19.20)
____Hepatitis due to alcohol (K70.10)
____Hiatal Hernia (K44.9)
____High Blood Pressure (I10)
____HIV
____Intestinal Bleeding (K92.2)
____Irritable Bowel Syndrome (K58.9)
____Kidney Disease (N18.3)
____Kidney Infection (N15.9)
____Kidney Stone (N20.0)
____Lyme Disease (A69.20)
____Osteoporosis
____Pancreatitis (K85.9)
____Peptic Ulcer (K27.3)
____Radiation Therapy, current or past
____Sleep Apnea (G47.30)
____Stroke
____Thyroid, overactive (E05.90)
____Thyroid, underactive (E03.9)
____Ulcerative Colitis

Do you have a personal history of any of the following: YES/NO

Colorectal, Gastric, Endometrial, Pancreatic or Ovarian Cancer? (Please circle) What age?_____

Surgical History: *Have you had any of the following surgeries? Please check all that apply and indicate what year.*

____Aneurysm repair
____Appendectomy
____Back surgery
____Blood transfusion prior to 1992
____Coronary artery bypass surgery
____C-Section
____Cancer operation
____Cardiac pacemaker placement
____Carotid artery surgery
____Colon surgery
____Gall bladder surgery
____Heart valve replacement
Which valve? _____
____Hernia repair
____Hysterectomy
____Implanted cardiac defibrillator
____Joint replacement
Which joint? _____
____Ovary removal
____Prostate surgery
____Thyroid surgery
____Weight loss surgery

In past colonoscopies, have you had 10 or more polyps? YES / NO

Where was your last colonoscopy performed? When?

Family History: *Do you have a family history of any of the following?*

YES / NO Colon or Rectal Cancer
Which relative? _____
YES / NO Crohn's Disease or Ulcerative Colitis
Which relative? _____
YES / NO Alcoholism
Which relative? _____
YES / NO Celiac Disease
Which relative? _____
YES / NO Were you or your mother born outside the United States?
Where? _____

Mother: Alive / Deceased (Please circle)
Please list medical problems or cause of death

Father: Alive / Deceased (Please circle)
Please list medical problems or cause of death

Siblings:

Have any family members been diagnosed with any of the following? YES / NO

Colorectal, Gastric, Endometrial, Pancreatic or Ovarian Cancer? (Please circle)

What family member(s) and what ages? _____

Social Habits:
YES / NO Tobacco Use How much per day? _____ If previous, when did you quit? _____

YES / NO Alcohol Use How much per week? _____ If previous, when did you quit? _____

YES / NO Recreational Drug Use Which drug(s)? _____ If previous, when did you quit? _____

PATIENT NAME: _____

Have you undergone recent diagnostic testing within the last six months? (Please circle)

1. CT Scan	YES / NO
2. MRI	YES / NO
3. Bloodwork	YES / NO
4. Upper GI Series	YES / NO
5. Barium Enema	YES / NO
6. Ultrasound	YES / NO
7. Colonoscopy	YES / NO
8. Upper Endoscopy (EGD)	YES / NO
9. Other Testing	YES / NO

If you have answered YES to any of the above, please bring paper copies of all reports on the day of your visit.

Thank you.

U.S Digestive Health

Patient Information Record

Please **PRINT** all information.

Date_____

Last Name_____ First Name_____ MI_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail Address _____Social Security #_____

Circle One: Sex M F Marital Status: S M W D Age_____ Date of Birth_____

Circle One – Ethnicity: Hispanic or Latino Not Hispanic or Latino Race_____ Language_____

Spouse's Name_____ Spouse's Work Phone_____

Spouse's Employer_____

Emergency Contact (other than spouse) _____Relationship_____

Emergency Contact Phone_____

Primary Care Doctor_____Phone_____

List other doctors seen regularly_____Phone_____

_____

Who recommended that you consult a gastroenterologist? _____

INSURANCE INFORMATION

Insurance company and address_____

Name of Policyholder_____Group#_____

Policy/ID#_____ Medicare#_____

Policyholder employer_____ Policyholder Date of Birth_____

Your appointment time has been set aside for you. We reserve the right to bill for missed and cancelled appointments. Please provide us with 24 hours' notice if you need to cancel your office visit and two business days if you need to cancel a procedure. Otherwise, missed or late cancellations may result in a discharge from the practice. Late cancellations delay the care for other patients who are waiting to be seen in a timely fashion. Please confirm though our automated system when you receive your reminder.

CONSENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I understand and agree that Main Line Gastroenterology Associates may provide treatment to me and may use and disclose protected health information about me for treatment, payment and/or health care operations. I authorize payment of medical benefits on my behalf to Main Line Gastroenterology Associates for services received. I also authorize the release of any medical or other information necessary to process my claims.

SIGNED: _____ DATE: _____

DO NOT MAIL THIS FORM

Site information/Label

Site: MLGA

Address:

HIPAA Contact Information

Patient Name: _____ Date of Birth: _____

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You may contact me by mail at my address on record ☐ Yes ☐ No

You may contact me by phone at my contact number on record ☐ Yes ☐ No

You may leave a message on my contact number on record ☐ Yes ☐ No

You may contact me/leave a message at the following number: _____

You may discuss my healthcare needs/release necessary medical information with family and/or others involved in my care as listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

Site information/Label

Site: MLGA

Address:

Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing Regional Gastroenterology Associates of Lancaster, d/b/a U.S. Digestive Health (USDH). USDH is committed to providing you with the best care possible, while minimizing your out-of-pocket expenses and making the payment of any private balances as easy as possible. In order to do this, our financial department will need your assistance and your understanding of our financial policy. Please read and sign this Financial Policy prior to your treatment.

We participate with most major insurance plans, including Medicare. If you are not insured by a plan with which we participate, payment in full is expected at each visit. If you are insured by a plan in which we participate, but you do not provide up-to-date insurance information, you will be considered self-pay until insurance coverage can be confirmed. It is your responsibility to know your insurance benefits. Please contact your insurance company with any coverage questions.

All patients must complete our patient registration process before seeing the physician or provider. We will need a copy of your identification card and a current valid health insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Insurance:
For your convenience we will submit claims to your insurance carrier for payment provided we are contracted with your chosen insurance. We will submit to primary, secondary and supplemental plans as needed.

It is your responsibility to provide USDH with current, accurate billing information at the time of your visit and to notify us of any changes in the information. If the information provided is inaccurate or inactive, you will be considered self-pay for services.

Co-payments are due at the time services are provided. This is a contractual agreement you have with your health plan and our contractual obligation with participating insurance carriers. If payments are not made at time of service, there may be a Co-Pay Billing Fee. USDH accepts cash, checks, debit cards and major credit cards. Returned checks are subject to a reasonable processing fee.

Referrals:

It is your responsibility to determine if you require a referral before your appointment. If you arrive without a referral and one is needed, you may be asked to either pay for your appointment in full before being seen or to reschedule your appointment pending the referral.

Pre-Authorizations:
USDH will obtain precertification for any services that require pre-authorization. Pre-authorization does not guarantee that the service will be covered or paid by your insurance carrier. Precertification is the process of notifying the insurance carrier of certain treatment services you will receive so the insurance carrier can determine medical necessity.

Our relationship is with the patient, not the insurance carrier. While pre-authorizations, referrals and the filing of insurance claims is a courtesy extended to our patients, all charges are your responsibility. If you disagree with a bill from our office, please contact your insurance company as the first step to determine the reason for any balance or non-coverage of a service. It is the patient's responsibility to contact their insurance carrier prior to treatment and service to determine specific guidelines for coverage, deductibles and co-pays based on your individual coverage.

Self-Pay:
You are expected to pay a minimum deposit of $65.00 for all office visits which will be applied to your total charge for services that day. Self-Pay discounts are offered and applied to your balance. Remaining balances paid within 30 days of the date of service are eligible for an additional prompt payment discount. If at any time you are unable to pay a balance due, please contact our office for assistance or to establish a payment plan.

Balances:
You have a financial responsibility to pay for any services received at USDH. This includes co-pays, co-insurance, deductibles, non-covered services and self-pay fees. Please understand that that if payment or a payment plan is not established after issuance of three statements, the balance on the account may be placed with a collection agency. Reasonable costs associated with collection efforts will be your responsibility.

I understand that I am financially responsible for any co-pays, co-insurance, deductibles, non-covered services and self-pay fees. I have read and understand this Financial Policy and by signing I accept all terms and conditions described above.

No Show and Cancellation Policy:
Last minute cancellations and no-shows prevent other patients from receiving necessary treatment and creates an added expense for the Practice and physician. To promote efficient access to our services, we request that you notify us at least 24 hours in advance if you cannot keep your appointment. In the event that an appointment is missed or cancelled with less than 24- hour notice, a $25.00 charge will be billed to your account.

_____ _____

Signature of Patient or Authorized Representative Date

Relationship to Patient: _____

Site information/Label

Site: MLGA

Address:

Notice of Privacy Practices Acknowledgement

Patient Name: _____ Date of Birth: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for treatment, payment and healthcare operations.

By signing this form, I acknowledge that I have viewed and have been offered a copy of U.S. Digestive Health's "Notice of Privacy Practices" ("NPP"). This NPP describes in detail how we might use or disclose your protected health information.

I understand that this organization has the right to change its NPP from time to time and I my request a copy of the NPP at any time or review it on the company website.

I am aware that I may request a copy of the NPP at any time and that a current version of the NPP is available at www.USDigestiveHealth.com under "Privacy Policy".

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

If Applicable

The patient refused or was unable to acknowledge the Notice of Privacy Practices (please indicate reason:

_____

_____

_____

_____ _____

Staff Representative Signature Date