SOUTHWEST GASTROENTEROLOGY ASSOCIATES

PHONE: (724) 941-3020
FAX: (724) 426-7713

RICHARD PANICCO, D.O. PHILIP JOSON, M.D.
RICHARD KENNEY, D.O. JENNIFER TOTTEN, M.D.

THERESA MELDON C.R.N.P.

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Gastroenterology New Patient/ Update Form
Please bring the **completed** form with you to your appointment.

Patient's name: _____ Date of Birth:_____ Age:_____ Today's Date:_____

Primary Care Physician:_____

Problem or Reason for your visit: _____

_____

Past Medical History (which of the following conditions are you currently being treated or have been treated for in the past) **PLEASE CHEK THE BOX IN THE COLUMN TO THE LEFT OF THE DIAGNOSIS.**

	Acid Reflux		Hemorrhoids		Arrhythmia		Anemia
	Stomach Ulcers		Anal Fissure		Hypertension		Bleeding Disorder
	Crohn's Disease		Hepatitis B		Endocarditis		Blood Clots
	Ulcerative Colitis		Hepatitis C		Emphysema		History of Transfusion
	Irritable Bowel Syndrome		Gallstones		COPD		Diabetes
	Colon Cancer		Liver Problems		Asthma		Stroke
	Colon Polyps		Pancreatitis		Seizure Disorder		Cancer (Type):
	Diverticulitis		Heart Attack		Kidney Disease		

Past Surgical/Procedure History (which of the following conditions are you currently being treated or have been treated for in the past) **PLEASE CHEK THE BOX IN THE COLUMN TO THE LEFT OF THE DIAGNOSIS.**

	Colon Resection		Gastric Bypass		Hysterectomy
	Small Bowel Resection		Organ Transplant		Endoscopic Ultrasound
	Appendectomy (Appendix Removal)		Artificial Heart Valve		Flexible Sigmoidoscopy
	Cholecystectomy (Gallbladder Removal)		Pacemaker/Defibrillator Placement (Circle One)		Colonoscopy/Endoscopy (Circle) Year/Location:
	Hemorrhoidectomy		Joint Replacement		Other:

Family History (age of diagnosis if known)

		MOTHER	FATHER	BROTHER	SISTER	GRANDPARENT	OTHER
	Colon Cancer						
	Colon Polyps						
	Ulcerative Colitis						
	Crohn's Disease						
	Celiac Disease						
	Liver Disease						
	Breast Cancer						
	Other Cancer						
	Diabetes Mellitus						
	Heart Disease						

Social History

SMOKING STATUS	Yes	No	Packs / Day	Amount of Years	Year Quit
Current Smoker					
Former Smoker					
Current Non-Smoker			XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
ALCOHOL CONSUMPTION			Drinks / Day	Amount of Years	Year Quit
Current Drinker					
Social Drinker					
Current Non-Drinker			XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX

Habits

CAFFEINE CONSUMPTION: Yes or No Cups / Day_____

RECREATIONAL DRUGS: Yes / No Usage / Day_____

Medication List (list current prescription and non-prescription medication)

MEDICATION NAME	DOSAGE	FREQUENCY / DAY	MEDICATION NAME	DOSAGE	FREQUENCY / DAY

Allergies

MEDICATION ALLERGIES: _____

LATEX ALLERGY: YES OR NO **ANESTHETIC ALLERGY OR REACTION:** YES OR NO **IF YES, DESCRIBE:** _____

PHARMACY NAME/LOCATION/PHONE: _____

Demographics

NAME:		**DATE OF BIRTH:**
SOCIAL SECURITY NUMBER:		
ADDRESS:	**PHONE NUMBER:** _____ CELL /HOME PERMISSION TO LEAVE VOICEMAIL YES / NO **ALTERNATE NUMBER:** _____	
EMERGENCY CONTACT:	**RELATIONSHIP:**	**PHONE NUMBER:**
OCCUPATION:		
MARITAL STATUS: S M D W	**LIVING ARRANGEMENTS:** ALONE SPOUSE/SIGNIFICANT OTHER SUPERVISED LIVING	

DIGESTIVE SYSTEM

___Difficulty in Swallowing

___Solids

___Liquids

___Heartburn / Esophageal Reflux

___Regurgitation

___Nausea / Vomiting / Both (CIRCLE ONE)

___Indigestion

___Early Satiety (fullness)

___Abdominal pain

___ Right Upper Quadrant

___Right Lower Quadrant

___Left Upper Quadrant

___Left Lower Quadrant

___Bloating / Belching / Gaseousness

___Gastrointestinal Bleeding

___Rectal Bleeding

___Hemorrhoids

____Anal / Rectal Pain

___Blood in Stool / Black Stool / Both (CIRCLE ONE)

___Change in Bowel Habits

___Constipation

___ How many bowel movements per week?

___Hard / Lumpy Stool

___Straining to Pass Stool

___Sensation of Incomplete Bowel Movement

___Diarrhea

___How many bowel movements per day?

___Fecal Incontinence

___Jaundice

HEMATOLOGIC

___Easy Bruising / Bleeding

SKIN

___Rash

GENERAL

___Weight Loss / Amount___Lbs.

___Fever / Chills

___Fatigue / Weakness

___ Loss of Appetite

RESPIRATORY

___Shortness of Breath

___Wheezing

___Cough

CARDIAC

___Chest Pain

___Palpitations

___Irregular Heartbeat

___Swelling in Legs

GENITOURINARY

___Pregnant

___Blood in Urine

___Frequent / Painful Urination

MUSCULOSKELETAL

___Joint Pain / Swelling

___Muscle Pain / Weakness (CIRCLE ONE)

___Back Pain

___Mobility Problems

NEUROLOGIC

___Numbness / Tingling / Weakness

___Dizziness

___Headache

___Seizure / Tremor

ENDOCRINE

___Heat / Cold Intolerance

___Excessive Thirst

PSYCHIATRIC

___Depression / Anxiety

___Excessive Stress

SOUTHWEST GASTROENTEROLOGY ASSOCIATES

HIPAA

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I, _____(your name), hereby authorize Southwest Gastroenterology Associates to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Southwest Gastroenterology Associates can refuse to treat me.

I have been informed that Southwest Gastroenterology Associates has prepared a notice ("Notice") which more fully describes that uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and healthcare operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Southwest Gastroenterology Associates, in writing, but if I revoke my consent, such revocation will not affect any actions that Southwest Gastroenterology Associates took before receiving my revocation.

I understand that Southwest Gastroenterology Associates has reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request Southwest Gastroenterology Associates to restrict how my individual identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that Southwest Gastroenterology Associates do not have to agree to such restrictions, but once such restrictions are agreed to, Southwest Gastroenterology Associates mut adhere to such restrictions.

HIPAA PRIVACY

I GIVE MY PERMISSION FOR SOUTHWEST GASTROENTEROLOGY ASSOCIATES TO DISCUSS ANY INFORMATION PERTAINING TO MY MEDICAL CARE OR CONDITION WITH THE FOLLOWING PEOPLE LISTED BELOW.

1. _____(RELATIONSHIP)_____
2. _____(RELATIONSHIP)_____
3. _____(RELATIONSHIP)_____
4. _____(RELATIONSHIP)_____

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

_____

PRINTED NAME OF PATIENT OR PATIENT'S REPRESENTATIVE

SOUTHWEST GASTROENTEROLOGY ASSOCIATES

80 LANDINGS DRIVE SUITE 205

WASHINGTON, PA 15301

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with the highest quality of care. In order to provide this care, it is essential that our office run as efficiently as possible. Proper payment of a bill is an important part of this process. The following is a statement of our financial policy. We ask that you read and sign the policy prior to your appointment.

1. **GENERAL INFORMATION** Your insurance policy is a contract between you and your insurance company. It is essential that you understand your benefits and obligations under that agreement. Some of the services provided may not be covered under your plan. Please contact your insurance company to ask if Southwest Gastroenterology Associates is a provider under your policy and if the procedure required is covered. As a courtesy, we file your insurance claims for office visits and procedures. When we file a claim on your behalf, it is understood that the payments will be assigned to Southwest Gastroenterology Associates. We can not bill your insurance carrier correctly unless you provide us with current insurance information. If you have two insurance policies, it is your responsibility to inform us which plan is primary and which plan is the secondary policy. Confusion of this issue can lead to long delays in payment from your insurance company and may hold you responsible for payment not received by them.

2. **MEDICARE PAYMENT POLICY** Southwest Gastroenterology is a participating provider under **Medicare.** This means Medicare will pay the doctor's office directly for 80% of the Medicare allowed charge, after the deductible has been met. The remaining 20% will be submitted to the supplemental insurance plan. We will submit all claims Medicare and to supplemental policies. The deductible and the remaining uncovered amount are your financial responsibility.

3. **PAST DUE ACCOUNTS AND RETURNED CHECKS** After we bill your insurance company, you will be responsible for the unpaid portion of their set fees. We will send you a bill. A balance due after 90 days or a portion of the balance due as agreed in prior payment arrangements, will result in transfer of the responsible party's account to collection. You will be responsible for the collection agencies fees. Your account will be charged $30.00 for each returned check.

4. **REFERRALS** Some insurance policies require an order from a primary care physician and a referral from the insurance company prior to seeing a specialist. Please check with your primary physician whether and electronic or paper referral is necessary. Some primary physicians require two weeks to grant a referral. I the referral is granted then have them fax it to our office at 724-426-7713. It is the responsibility of the patient to obtain all appropriate referrals prior to delivery of service. If the appropriate referrals are not obtained before the time of service, the patient will be personally/financially responsible for all charges. Theses referrals often have an expiration date and limited number of visits so please monitor the dates and visits.

5. **CO-PAYMENTS, COINSURANCE, AND DEDUCTIBLES** Patients are responsible for paying co-payments, co-insurance, and deductibles. Most insurance companies pay a percentage of their allowable fee and the coinsurance is the remaining portion of that fee. Each year your insurance company requires you to pay a set amount out-of-pocket, in addition to your deductible. We will bill you for these charges and you are legally responsible for them.

6. **USUAL AND CUSTOMARY RATES** Our practice is committed to providing the best treatment for our patients and our charges are what is usual and customary for our area. Under some insurance plans, you may be responsible for payment of theses charges of the insurance company's rate schedule.

7. **MISSED APPOINTMENTS** Our no-show policy is to charge for missed appointments not canceled with our office. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your scheduled appointments. **OUR NO-SHOW CHARGE IS $25.00 EACH APPOINTMENT.** After **THREE MISSED APPOINTMENTS WE WILL DISMISS YOU FROM OUR PRACTICE.**

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE

_____ PRINTED NAME OF PATIENT OR PATIENT'S REPRESENTATIVE