



# Gastrointestinal Associates, P.A.

*Diplomats of the American Board of Internal Medicine and Gastroenterology*

## Gastrointestinal Associates, P.A. CONSENT TO LEAVE INFORMATION

Dear Patient,

Gastrointestinal Associates has adopted a policy that requires their staff to obtain authorization from the patient to leave detailed messages for the patient if they are not available. This policy is to protect the privacy of the patient and also to protect Gastrointestinal Associates and its staff from violating the patient's confidentiality. If there is not a signed consent on file, our staff will only leave their name and phone number on an answering machine, voice mail, or with the person answering the phone asking the patient to return the call.

By completing the consent form below, you are allowing the staff of Gastrointestinal Associates to leave a detailed message on an answering machine, voice mail or with a specified individual. You can specify what information can be left and with whom. By signing the form you are also consenting to the mailing or faxing of any results requested by you, your primary care physician or another physician involved in your care.

I give my consent to the staff of Gastrointestinal Associates to leave a message regarding treatment, lab results, radiology results, or any other information necessary.

- On an answering machine or voice mail, cell phone or via email at home.
- On an answering machine or voice mail, cell phone or via email at work.
- I do not consent to messages being left at home, work, or with any other person. I wish to be contacted directly.

The following individuals may discuss my care and financial responsibilities with Gastrointestinal Associates, P.A.

With \_\_\_\_\_ Relationship \_\_\_\_\_

With \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

GA147

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KC-GI.COM

*Gastrointestinal Associates*  
*Financial Policy*

Gastrointestinal Associates, PA contracts with several insurance programs. If you would like for our office to file an insurance claim for your services, it is your responsibility to present a current insurance card at the time of service. We will file claims for primary and secondary insurances. We are pleased to be able to provide this service for you, however it is **your** responsibility to inform our office of your insurance policy restrictions and guidelines in regard to how often and where you may receive services. If your insurance policy requires prior authorization or a referral from a primary care physician, it is your responsibility to obtain that information. If your insurance policy requires that you select a physician from a list of providers, it is your responsibility to schedule your appointment with a provider on that list.

Unfortunately, if you do not inform us of requirements in your insurance policy or obtain your referral and we order services such as lab work, endoscopic procedures or hospitalization, that are not covered, we or the medical facility will have no choice but to bill you directly for those charges. Payment of those charges is your responsibility.

Co-payments and deductibles are due in full at time of service. Patients with no insurance must contact our business office at 913-541-0510 **prior** to your appointment to make satisfactory payment arrangements. Our business office will call to verify insurance benefits on all scheduled procedures. We will estimate the patient responsibility and contact you with that information. The patient responsibility, which includes deductible and co-insurance, is due **prior** to your procedure.

Gastrointestinal Associates will follow up on unpaid insurance claims. However, your policy is an agreement between you and your insurance company and it is your responsibility to assure that claims for your services here are paid.

Gastrointestinal Associates does **not** file claims to auto or liability insurance. All charges are due at the time of service and we will provide you with the information you need to file a claim for reimbursement from the insurance company.

Gastrointestinal Associates does not charge interest on unpaid account balance. We are glad to set up a monthly payment schedule on balances over \$100.00, however, we are unable to finance balances for longer than 6 months. Therefore, please be aware that any monthly payment plan for deductibles and balances after insurance will only be extended for 6 months from the date the insurance payment is received. This arrangement is not available for Remicade balances or balances due before an out-patient procedure.

***I have read and understand the financial policy stated above and agree to accept responsibility as described.***

\_\_\_\_\_ signature

\_\_\_\_\_ date



**Gastrointestinal Associates, PA.**

## Patient Registration Information

*Please PRINT AND complete ALL sections below!*

Please give to the doctor at your scheduled appointment.

- WILLIAM A. HARTONG, M.D.
- WILLIAM D. BUSER, M.D.
- JOHN A. THESING, M.D.
- JAMES A. MAVEC, M.D.
- JEFF L. YOUNG, M.D.
- DONNA M. GRAESSLE, D.O.
- RANDAL L. BROWN, M.D.
- J. CHRIS NICHOLS, M.D.
- CHRISTIAN C. MCELHINNEY, M.D.

Date: \_\_\_\_\_

Marital status:  Single  Married

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex M  F

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ Home Phone #: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ SS: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

e-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

### EMERGENCY CONTACT (Friend or relative not living with you)

Name: \_\_\_\_\_ Sex M  F

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ Home Phone #: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Party:  Self  Other \_\_\_\_\_

### Insurance Information:

#### Primary Insurance:

#### Secondary Insurance:

Name of Ins. Co. \_\_\_\_\_ Name of Ins. Co. \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City & St \_\_\_\_\_ Zip \_\_\_\_\_ City & St \_\_\_\_\_ Zip \_\_\_\_\_

Policy/ID Number \_\_\_\_\_ Group \_\_\_\_\_ Policy/ID Number \_\_\_\_\_ Group \_\_\_\_\_

Medicare ID \_\_\_\_\_ Medicare ID \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_\_ Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_\_

Is this insurance thru Employer \_\_\_\_\_ Is this insurance thru Employer \_\_\_\_\_

Group Name \_\_\_\_\_ Group Name \_\_\_\_\_

Do you have other Insurance? \_\_\_\_\_

Patient is seeing Dr. due to: Accident  Illness  Injury

Have you or any member of your family been treated by our physicians before:  Yes  No

Drug Allergies, if any: \_\_\_\_\_ Reaction \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Authorization of Treatment**

While I am here I permit the employees, the healthcare provider, and all other person caring for me to treat me in ways they judge are beneficial to me. I understand the attending healthcare provider will explain to me the nature of my condition and his/her recommended treatment and any associated risk involved. I further understand that this care may include diagnostic testing, examinations, medical and/or surgical treatment and no guarantees have been made to me about the outcome of this care.

**Medicare / Medicaid Lifetime Consent**

I certify that the information given me in applying under Title XVII of the Social Security Act is correct. I authorize any holder of medical and/or other information about me to release it to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to the healthcare provider or organization to submit a claim to Medicare for payment to me.

**All Other Insurance**

Authorization is hereby granted to Gastrointestinal Associates, PA. to release medical records and such information as may be requested for the completion of my claims to my insurance company. I further authorize payment for medical benefits to be made directly to Gastrointestinal Associates, PA.

I understand that I am personally responsible for all Services provided by Gastrointestinal Associates, PA.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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Signature \_\_\_\_\_ Date \_\_\_\_\_



**HISTORY & PHYSICAL**

PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT

**Patient Identification**

DATE: \_\_\_ / \_\_\_ / \_\_\_

Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle)  
Age: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Sex: \_\_\_ Male \_\_\_ Female  
Race: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

**Chief Complaint**

(Stated as simply as possible. Include type of complaint: mass, pain\*, abnormal test, fever, weight change, etc. Include duration of symptoms.)

\_\_\_\_\_

\* If the chief complaint is **pain**, it is best described as:

- |                                   |                                       |                                     |                                      |
|-----------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Severe   | <input type="checkbox"/> Moderate     | <input type="checkbox"/> Mild       | <input type="checkbox"/> Needle-like |
| <input type="checkbox"/> Periodic | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Burning    | <input type="checkbox"/> Superficial |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Cramping     | <input type="checkbox"/> Deep       | <input type="checkbox"/> Sudden      |
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Dull         | <input type="checkbox"/> Gnawing    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gradual  | <input type="checkbox"/> Shifting     | <input type="checkbox"/> Continuous | _____                                |

**History of the Present Illness**

Date of onset: \_\_\_ / \_\_\_ / \_\_\_

Initial Symptoms: \_\_\_\_\_

Progression of Symptoms: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What initiates symptoms? \_\_\_\_\_

What relieves symptoms? \_\_\_\_\_

Associated symptoms: \_\_\_\_\_

Character of symptoms recently:  More Frequent  More Intense  Continuous  
 Less Frequent  Less Intense  Periodic

# Past Medical History

Name: \_\_\_\_\_

(Check those conditions that apply.)

**Previous Illnesses:**

**Anemia**

- Iron Deficiency
- Vitamin B12 Deficiency
- Other

**Blood Disease**

- Leukemia
- Bleeding Disorder
- Blood Clots
- Phlebitis
- Clotted Veins
- Clotting Problems
- Other

**Cancer**

Type \_\_\_\_\_

**Cardiovascular**

- Heart Attack
- Heart Stents
- Murmur
- Hypertension
- High Cholesterol
- High Triglycerides
- Angina/Chest Pain
- Heart Valve
- Other

**Communicable Diseases**

- Rheumatic Fever
- Polio
- Parasites
- Dysentery
- Syphilis
- Gonorrhea
- Other

**Endocrine**

- Diabetes
- Thyroid
- Goiter
- Other

**ENT**

- Sinusitis
- Hay Fever
- Blurred Vision
- Cataracts
- Other

**Misc**

- Gout
- Arthritis
- Skin Problems
- Muscle Problems
- Hernia
- Other

**Gastrointestinal**

- Ulcer
- Gastritis
- Duodenitis
- Hiatal Hernia
- Gallstones
- Pancreatitis
- Colon Polyp
- Diverticulosis
- Diverticulitis
- Ulcerative Colitis
- Crohns
- Hemorrhoids
- Fissure/Abscess
- Irritable Bowel Syndrome
- Bowel Obstruction
- Other

**Genitourinary**

- Kidney Infection
- Kidney Stone(s)
- Bladder Trouble
- Prostate Growth
- Sexual Problems
- Gynecological Problems
- Other

**Liver**

- Jaundice
- Hepatitis
- Other

**Neurology**

- Epilepsy
- Multiple Sclerosis
- Stroke/TIA
- Paralysis
- Headaches
- Other

**Psychological**

- Mental Illness
- Nervousness
- Other

**Pulmonary**

- Emphysema
- Bronchitis
- Pneumonia
- Asthma
- TB
- Pleurisy
- Other

**Vaccines**

- Hepatitis A
- Hepatitis B
- Tetanus

Comments: (Explain anything marked &/or numbered above, if necessary.) \_\_\_\_\_

**Hospitalizations:** (Include all major illnesses, injuries, & operations.)

Date	Hospital	Diagnosis	Treatment	Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Allergies:**

Agent or Medication:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

**Current Medications:**

Medication:	Dosage:	Frequency:	Duration of use:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# Review of Systems

Name: \_\_\_\_\_

(Check those which have occurred recently.)

## General

- Weight gain
- Weight loss
- Weakness
- Fatigue
- Fever
- Chills
- Night sweats
- Fainting

## Skin

- Color changes
- Nail changes
- Hair changes
- Mole changes
- Rashes
- Itching
- Sores
- Dryness

## Head

- Headaches
- Injuries
- Bumps/Lumps
- Glasses
- Contacts

## Eyes

- Blurred vision
- Cataracts
- Glaucoma
- Redness/Itching
- Burning
- Swelling
- Pain
- Dryness
- Tearing

## Ears

- Hard of hearing
- Deafness
- Ringing
- Discharge
- Earache
- Itching
- Loss of balance
- Dizziness
- Room spins

## Nose

- Decreased smell
- Bleeding
- Pain
- Discharge
- Obstruction
- Post nasal drip
- Deviated septum
- "Rummy" nose
- Sinus congestion

## Mouth

- Bleeding gums
- Sores
- Dental problem
- Pain
- Bad breath
- Loss of taste
- Dry mouth
- Ulcers
- Blisters

## Throat

- Soreness
- "Bad" tonsils
- Hoarseness
- Pain
- Trouble swallowing
- Recurrent infections

## Neck

- Enlargement
- Stiffness
- Soreness
- Lumps
- Masses

## Breasts

- Discharge
- Lumps
- Pain
- Bleeding
- Nipple changes
- Skin changes
- Fullness

## Lungs

- Cough
- Phlegm
- Blood in sputum
- Short of breath
- Wheezing
- Pain
- Congestion
- Inhalant exposure

## Heart

- Murmur
- Palpitations
- Rapid heart beat
- Swollen legs
- Cold extremities
- Chest pain
- Chest pressure
- Varicose veins
- Blood clots
- Blue extremities

## Blood

- Anemia
- Low Blood Iron
- Easy bruising
- Easy bleeding
- Swollen nodes
- Painful nodes
- Sugar in blood
- Red spots

## Gastrointestinal

- Abdominal pain
- Nausea
- Vomiting
- Bloating
- Belching
- Heartburn
- Indigestion
- Irregular bowel habits
- Constipation

## Gastrointestinal

- Diarrhea
- Gas
- Hemorrhoids
- Hernia
- Poor appetite
- Food intolerance
- Bloody stools
- Black stools

## Genitourinary

- Urgency
- Incontinence
- Straining
- Back pain
- Frequent voiding
- Stones
- Burning
- Bed wetting
- Bloody urine

## Genitourinary

- Small stream
- Discharge
- Sores
- Impotence
- Dribbling
- Cloudy urine

## Gynecological

- Spotting
- Menstrual cramps
- Discharge
- Itching
- Painful intercourse
- Irregular periods
- Hot flashes

## Gynecological

- Contraception
- Age at 1st period
- Age at menopause
- Duration of cycle
- Duration of flow
- # of pregnancies
- # of births
- # of miscarriages
- # of abortions

## Gynecological

- Menstrual flow  
(Heavy, Mod, Light)
- / / / LMP
- Hysterectomy
- Other \_\_\_\_\_

## Musculoskeletal

- Muscle pain
- Muscle weakness
- Muscle cramps
- Joint pain/swelling
- Back pain
- Other \_\_\_\_\_

## Neurological

- Seizures
- Dizziness
- Sensory loss
- Paralysis
- Memory loss
- Numbness

## Psychiatric

- Anxiety
- Depression
- Irritability
- Hallucinations
- Drug Dependency
- Suicidal tendency

## Endocrine

- Heat intolerance
- Cold intolerance
- Voice changes
- Extreme thirst
- Breast changes

Name: \_\_\_\_\_

**Family History**

Relationship	Age (Living)	Age (At Death)	State of Health / Illnesses / Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings _____	_____	_____	_____
_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Other _____	_____	_____	_____
_____	_____	_____	_____

**Social History**

**Current weight** \_\_\_\_\_ **Usual weight:** \_\_\_\_\_ **Maximum weight:** \_\_\_\_\_ **Minimum weight:** \_\_\_\_\_  
**Marital status:** \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced  
**Mental work:** \_\_\_\_\_ Strenuous \_\_\_\_\_ Moderate \_\_\_\_\_ Light \_\_\_\_\_ Hours/Day  
**Physical work:** \_\_\_\_\_ Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light \_\_\_\_\_ Hours/Day  
**Exercise:** \_\_\_\_\_ Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light \_\_\_\_\_ Hours/Week  
 Type of Exercise: \_\_\_\_\_  
**Tobacco use:** \_\_\_\_\_ Packs/Day \_\_\_\_\_ Packs/Day \_\_\_\_\_ No. of years \_\_\_\_\_ Quit  
 (Currently) (Previously) (mo/year)  
**Alcohol use:** \_\_\_\_\_ Amount per Week  
**Caffeine use:** \_\_\_\_\_ Cups per day (Coffee, tea, cola)  
**Drugs:** (List the number of doses per week.)  
 \_\_\_\_\_ Vitamins \_\_\_\_\_ Antacids \_\_\_\_\_ Pain Pills \_\_\_\_\_ Nerve Pills \_\_\_\_\_ Potassium  
 \_\_\_\_\_ Laxatives \_\_\_\_\_ Diet Pills \_\_\_\_\_ Sleeping Pills \_\_\_\_\_ Diuretics \_\_\_\_\_ Nutrasweet  
 \_\_\_\_\_ Aspirin \_\_\_\_\_ Motrin \_\_\_\_\_ Ibuprofen \_\_\_\_\_ Advil \_\_\_\_\_ Naprosyn  
 \_\_\_\_\_ Other \_\_\_\_\_  
**Nutrition:**  
 \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor  
 Types of foods most commonly eaten: \_\_\_\_\_  
 Types of foods most commonly avoided: \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

This history will become part of the permanent record.  
 Completed by: \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Reviewed by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_