Gastrointestinal Associates, LLC.

Patient Registration Form

☐ Return this paperwork immediately
Mail: 10116 W. 105th St. Fax: 913-541-1852
Overland Park, KS 66212

☐ Bring these forms with you to your appointment
Appointment Date: _____
☐ Office Visit ☐ Procedure

☐ John A. Thesing, M.D.
☐ James A. Mavec, M.D.
☐ Jeff L. Young, M.D.
☐ Randal L. Brown, M.D.
☐ J. Chris Nichols, M.D.
☐ Christian C. McElhinney, M.D.
☐ John B. Sturgeon, M.D.
☐ Dushyant Singh, M.D.
☐ Donald J. Martin, M.D.
☐ S. Robert Holmes, D.O.
☐ Jessica A. Taylor, PA-C
☐ Kelci Gillenwater, APRN
☐ Celeste McGlamery, APRN
☐ Tracy Hill, APRN

Please PRINT & complete ALL selections:

Patient Name: _____ Date of Birth: _____

SSN: _____ Sex: Male/Female Marital Status: _____

Address: _____Apt_____ City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

Email: _____

Race: ☐White ☐Black/African-American ☐Amer. Indian/Alaskan Native ☐ Asian ☐Hawaiian/Other Pacific Island ☐Other Race

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Decline to Specify ☐Unknown Language:_____

Employer Name: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Primary Care Physician:	Phone Number: Fax Number:

Primary Insurance:	Member ID:	Group #:
Policy Holder's Name:	***Relationship:***	***DOB:***
Claims Mailing Address:		

Secondary Insurance:	Member ID:	Group #:
Policy Holder's Name:	***Relationship:***	***DOB:***
Claims Mailing Address:		

CONTINUE ON BACK SIDE →

Patient Name: _____

Date of Birth: _____

COMMUNICATION AUTHORIZATION

METHOD OF DISCLOSURE:

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of the protected health information. Please indicate how you wish to be contacted for scheduling, treatment, test results, financial or other information regarding your care (check all that apply):

☐ Home phone:	☐ Detailed message	☐ General message with call back # only
☐ Cell phone:	☐ Detailed message	☐ General message with call back # only
☐ Work phone:	☐ Detailed message	☐ General message with call back # only

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby allow Gastrointestinal Associates, LLC, to discuss scheduling, treatment, test results, financial or other information regarding my care with the following individuals. This consent will be considered valid until such time that I revoke it. It will be my responsibility to keep this information up to date, as I recognize that relationships may change.

Name:	Relationship:	Contact #:

Authorization of Treatment: While I am here I permit the employees, healthcare provider, and all other persons caring for me to treat me in ways they judge beneficial to me. I understand the attending healthcare provider will explain to me the nature of my condition and his/her recommended treatment and 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 by me in applying under Title XVIII 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 as needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits to the healthcare provider or organization to submit a claim to Medicare for payment to them.

All Other Insurance: Authorization is hereby granted to Gastrointestinal Associates, LLC and any associated healthcare entities to release medical records and required information as requested for completion of my claims to my insurance company. I further authorize payment for medical benefits to be made directly to Gastrointestinal Associates, LLC.

I understand that I am personally responsible for all services provided by Gastrointestinal Associates, LLC and any associated healthcare entities.

I understand my disclosure of health information & any changes must be made in writing.

By signing below I agree & acknowledge the following terms & that all information provided is accurate.

_____	_____	_____
Patient Signature	***Patient Representative Signature/Relation***	***Date***

Gastrointestinal Associates, LLC
Diplomats of the American Board of Internal Medicine and Gastroenterology

Patient Name: _____

Date of Birth: _____

Date: _____

History of Present Illness

Initial Symptoms: _____
Date of Onset: _____
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

Review of Systems

Check those which have occurred recently:

General
___Weight gain
___Weight loss
___Weakness
___Fatigue
___Fever
___Chills
___Night sweats
___Fainting
___Dizziness

Gastrointestinal
___Abdominal pain
___Nausea
___Vomiting
___Bloating
___Belching
___Heartburn
___Irregular bowel habits
___Constipation
___Diarrhea
___Gas
___Hemorrhoids
___Hernia
___Poor appetite
___Food intolerances
___Blood in stool
___Black stools

Lungs
___Cough
___Phlegm
___Blood in sputum
___Short of breath
___Wheezing
___Pain
___Congestion
___Inhalant exposure

Genitourinary
___Urgency
___Incontinence
___Straining
___Back pain
___Frequent voiding
___Stones
___Burning
___Blood in urine
___Small stream
___Discharge
___Sores
___Impotence
___Dribbling

Musculoskeletal
___Muscle pain
___Muscle weakness
___Muscle cramps
___Joint pain/swelling
___Back pain

Skin
___Color changes
___Nail changes
___Hair changes
___Mole changes
___Rashes
___Itching
___Sores
___Dryness

Mouth
___Bleeding gums
___Sores
___Dental problems
___Pain
___Bad breath
___Loss of taste
___Dry mouth
___Ulcers
___Blisters

Heart
___Murmur
___Palpitations
___Rapid heart beat
___Swollen legs
___Cold extremities
___Chest pain
___Chest pressure
___Varicose veins
___Blood clots

Neurological
___Seizures
___Dizziness
___Sensory loss
___Paralysis
___Memory loss
___Numbness

Head
___Headaches
___Injuries
___Bumps/lumps

Throat
___Soreness
___Hoarseness
___Pain
___Trouble swallowing
___Recurrent infections

Blood
___Anemia
___Low blood iron
___Easy bruising
___Easy bleeding
___Swollen nodes
___Painful nodes
___Red spots

Gynecological
___Spotting
___Menstrual cramps
___Discharge
___Itching
___Painful intercourse
___Irregular periods
___Hot flashes
___Contraception
___Age at 1st period
___Age at menopause
___Duration of cycle
___Duration of flow
___Menstrual flow
Heavy/moderate/light
LMP ___/___/____
___# of pregnancies
___# of births
___# of miscarriages
___# of abortions
___hysterectomy

Breast
___Discharge
___Lumps
___Pain
___Bleeding
___Nipple discharge
___Skin changes
___Fullness

Psychiatric
___Anxiety
___Depression
___Irritability
___Hallucinations
___Drug dependency

Eyes
___Blurred vision
___Cataracts
___Glaucoma
___Redness
___Itching
___Burning
___Swelling
___Pain
___Dryness
___Tearing

Ears
___Hard of hearing
___Deafness
___Ringing
___Discharge
___Earache
___Itching
___Loss of balance

Nose
___Decreased smell
___Bleeding
___Pain
___Discharge
___Obstruction
___Post nasal drip
___Deviated septum
___Sinus congestion

Neck
___Enlargement
___Stiffness
___Soreness
___Lumps
___Masses

Endocrine
___Heat intolerance
___Cold intolerance
___Voice changes
___Extreme thirst
___Breast changes

Medications & Allergies

Patient Name: _____

Date of Birth: _____

**** PLEASE TYPE OR PRINT CLEARLY ****

List ALL Prescription, Over-the-counter and Supplements

NAME	DOSAGE	FREQUENCY
EXAMPLE: Aspirin	81mg	1 time/day

Pharmacy:_____**Location:**_____

Phone:_____**Fax:**_____

☐ **No Known Drug Allergies**

ALLERGIES:	REACTION:

Past Medical History

Patient Name: _____

Date of Birth: _____

Previous Illnesses: (Check all that apply)

ANEMIA
____ Iron Deficiency
____ Vitamin B12 Deficiency
____ Other _____

BLOOD DISEASE
____ Leukemia
____ Bleeding Disorder
____ Blood Clots
____ Phlebitis
____ Clotted Veins
____ Clotting Problems
____ Other _____

CARDIOVASCULAR
____ Heart Attack
____ Heart Stents
____ Murmur
____ Hypertension
____ High Cholesterol
____ High Triglycerides
____ Angina/Chest Pain
____ Mitral Valve Prolapse
____ Atrial Fibrillation
____ Coronary Artery Disease
____ Pacemaker
____ Implanted Cardioverter
____ Other _____

COMMUNICABLE DISEASES
____ Rheumatic Fever
____ Polio
____ Parasites
____ Dysentery
____ Syphilis
____ Gonorrhea
____ HIV
____ Chlamydia
____ Other _____

ENDOCRINE
____ Diabetes Type I
____ Diabetes Type II
____ Hyperthyroid
____ Hypothyroid
____ Goiter
____ Other _____

ENT
____ Sinusitis
____ Seasonal Allergies
____ Blurred Vision
____ Cataracts
____ Sleep Apnea
____ Other _____

GASTROINTESTINAL
____ Duodenal Ulcer
____ Gastric Ulcer
____ Duodenitis
____ Hiatal Hernia
____ Gallstones
____ Pancreatitis
____ Colon Polyp
____ Diverticulosis
____ Diverticulitis
____ Ulcerative Colitis
____ Crohn's Disease
____ Hemorrhoids
____ Anal Fissure
____ Fistula
____ Irritable Bowel Syndrome
____ Bowel Obstruction
____ GERD (reflux)
____ Barrett's Esophagus
____ Gastroparesis
____ Lymphocytic Colitis
____ Collagenous Colitis
____ C. diff
____ Other _____

GENITOURINARY
____ Kidney Infection
____ Kidney Stones
____ Increased Urination
____ Prostatitis
____ Sexual Problems
____ Gynecological Problems
____ Other _____

NEUROLOGY
____ Epilepsy
____ Multiple Sclerosis
____ Stroke/CVA
____ TIA
____ Paralysis
____ Headaches
____ Other _____

PSYCHOLOGICAL
____ Depression
____ Mental Illness
____ Nervousness
____ Anxiety
____ Other _____

PULMONARY
____ Emphysema
____ Bronchitis
____ Pneumonia
____ Asthma
____ TB
____ Pleurisy
____ COPD
____ Other _____

VACCINES
____ Hepatitis A
____ Hepatitis B
____ Tetanus
____ Pneumonia

MISC
____ Gout
____ Arthritis
____ Skin Problems
____ Fibromyalgia
____ Hernia-Type_____
____ Osteoporosis
____ Vitamin D Deficiency
____ Osteopenia
____ Other _____

CANCER
Type _____

LIVER
____ Jaundice
____ Hepatitis
____ A
____ B
____ C
____ Cirrhosis
____ Ascites
____ Other _____

Date of last Colonoscopy: _____

Previous Surgery

Date	Surgery	Physician/Hospital

Family History

Patient Name: _____

Date of Birth: _____

Family History Unknown/Patient Adopted ☐
Please mark all that apply

Diagnosis	Living (circle one)	Colon Cancer	Colon Polyps	Ulcerative Colitis	Crohns Disease	Ulcer	Gallbladder Disease	Hepatitis	Liver Disease/Cancer	Stomach Cancer	Pancreatic Disease/Cancer	Breast Cancer	Uterine Cancer	Celiac Disease	Other	
Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Brother(s)	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
Sister(s)	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Children	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
PG-Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
PG-Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
MG-Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
MG-Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Social History

Occupation: _____

Alcohol Use:
☐None ☐Beer (____ bottles per week) ☐Wine (____ glasses per week) ☐Hard Liquor (____ drinks per day)

Caffeine Use:
☐None ☐1-2 per day ☐3-4 per day ☐more than 5 per day

Tobacco Use:
☐Never a smoker ☐Current Every Day Smoker (_____ packs per day, _____ # of years)
☐Current Some Day Smoker ☐Former Smoker (quit date _____)
Chewing Nicotine Containing Substance (Chewing tobacco) ☐Current ☐Former

Recreational Drug Use:
☐Never ☐Currently Using IV drugs ☐Used IV drugs in the past

Gastrointestinal Associates, LLC

Patient Financial Responsibility Form

The physicians at our office are contracted with a variety of insurance plans. We also provide services for private pay patients. We will submit claims, on your behalf, to your primary insurance carrier and one secondary insurance carrier (if applicable). Our office does not contract or file claims with **health share plans or auto and liability insurances**. Payment is required at time of service and we will provide you with an itemized statement to file for reimbursement from the insurance company.

Please remember your health insurance is an agreement between you and your insurer. It is your responsibility to know and understand the coverage, benefits and requirements of your health insurance plan. If you would like us to submit a claim for your services you must present a current insurance card at the time of service. If your health insurance requires a copay please be prepared to pay the copay at the time of service. We accept cash, check, Visa, Mastercard, Discover or American Express. If you are not prepared to pay your copay or private pay balance at the time of service, it may be necessary to reschedule your appointment.

If you have an out-patient procedure you may receive charges from the physician, facility, anesthesiologist or pathologist. Our office only has information related to the physicians' charges and, in some instances, the pathologists' charges. We can provide you with the phone numbers to contact the other offices for information regarding their charges.

Our office does not offer long term financing of balances for healthcare services we provide. Limited payment plans may be available but must be approved by our Business Office Manager. In the event your balance is not paid timely and we must employ a collection agency or attorney, all interest and/or fees for collection will be the responsibility of the patient in addition to the balance for healthcare services received.

Credit Card/Debit Card Authorization Policy

Our policy is that a credit card, debit card or HSA card information be securely stored for payment of patient balances after insurance or for private pay. There are a small number of insurance plans that are excluded from this policy. Our Registration Department will inform you if your plan meets these exclusions. If you do not wish to leave a credit card on file, we will collect, in advance, an **estimated** patient responsibility based on our contracted rate with your insurance company. This will be an **ESTIMATE** only and there may be additional charges as exact amounts cannot be determined prior to your procedure. A credit or debit card on file will be charged only if your account has a balance more than 30 days past due. If you do not provide a credit or debit card or pay an estimated patient responsibility, prior to being seen by our providers, it may be necessary to reschedule your appointment. If there is an overpayment on your account we will mail a refund check to the patient address on file. Your signature below indicates that you understand this policy.

Our business office will verify that your insurance policy is active, **for the physician only**, on scheduled procedures. This is not a guarantee of payment as your insurance company will determine payment after they receive a claim from our office. If you need more detailed policy information, you will need to contact your insurance company. After your insurance company processes your claim, Gastrointestinal Associates, LLC will mail a statement to the address on file providing you with any balance due that is your responsibility. If you have questions about your bill, you must contact the business office at **913-541-0510.**

By my signature below, I authorize Gastrointestinal Associates, LLC to securely store my credit card information and only charge it should I have an outstanding balance or any balance from a processed claim in the future. I am aware that the storage system used is fully compliant to the highest level of credit card storage security and regulations. Once stored, I am aware that only the last 4 digits of my card are viewable by Gastrointestinal Associates, LLC personnel. I understand that I am responsible for all charges for services that I receive from Gastrointestinal Associates, LLC and that if the patient responsibility portion of my charges (including charges applied to my deductible and/or coinsurance) is not paid in full within 30 days following receipt of the patient statement mailed to the address on file, Gastrointestinal Associates, LLC will charge my stored credit card for the outstanding balance due. I understand should I make a claim of fraud to charges on my credit card, as described in this policy, I will be responsible for payment of the balance for services received and all fees associated with the dispute.

I have read, understand and agree to the provisions of the Patient Financial Responsibility Form.

_____ _____

Patient Name (printed) ***Patient Date of Birth***

_____ _____

Signature ***Date***