



# Gastrointestinal Associates, LLC.

## Patient Registration Form

- Return this paperwork immediately  
Mail: 10116 W. 105<sup>th</sup> 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.
- 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:
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<u>Primary Insurance:</u>	Member ID:	Group #:
<b><i>Policy Holder's Name:</i></b>	<b><i>Relationship:</i></b>	<b><i>DOB:</i></b>
Claims Mailing Address:		

<u>Secondary Insurance:</u>	Member ID:	Group #:
<b><i>Policy Holder's Name:</i></b>	<b><i>Relationship:</i></b>	<b><i>DOB:</i></b>
Claims Mailing Address:		

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 reminders, financial information and test results (check all that apply):

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Home phone: | <input type="checkbox"/> Detailed message | <input type="checkbox"/> General message with call back # only |
| <input type="checkbox"/> Cell phone: | <input type="checkbox"/> Detailed message | <input type="checkbox"/> General message with call back # only |
| <input type="checkbox"/> Work phone: | <input type="checkbox"/> Detailed message | <input type="checkbox"/> General message with call back # only |

**PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby allow Gastrointestinal Associates, LLC, to disclose my protected health information to the following people because they are involved with my health care or payment. 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.

<u>Name:</u>	<u>Relationship:</u>	<u>Contact #:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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 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.  
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*

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  
 Less Frequent

More Intense  
 Less Intense

Continuous  
 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 1<sup>st</sup> 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





## 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	Y/N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)	Y/N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)	Y/N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	Y/N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PG-Father	Y/N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PG-Mother	Y/N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MG-Father	Y/N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MG-Mother	Y/N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 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

**Drug Use:**

Never       Currently Using IV drugs       Used IV drugs in the past

Recreational drug use:  Current       Former

**Gastrointestinal Associates, LLC**

**Financial Policy**

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, auto or 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 you do not have your card with you, payment at the time of service is required. You may provide the insurance information to our business office within 30 days, and we will submit a claim for you. Upon receipt of payment from your insurance we will process a refund to you for any over-payment.

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 requires that a credit card or debit card be placed on file prior to being seen by our providers.**

This card will be charged only if your account has a balance more than 30 days past due. Co-pays or Private pays will be collected at the time of service. We will verify that the credit or debit card is a valid, active account at the time it is received. If you do not provide a credit or debit card prior to being seen by our providers, it may be necessary to reschedule your appointment.

Our business office will verify insurance benefits, **for the physician only**, on scheduled procedures. This insurance verification is not required and is not a guarantee of payment as your health insurance 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. We will not process payment on the credit/debit card until after we have filed a claim and received a response from your health insurance company.

After each visit with us we will file a claim, on your behalf, to your health 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 we do not receive payment within 30 days from the statement date, we will process the balance due to your card on file. If you have questions about your bill, you must contact the business office at 913-541-0510, prior to that time.

The security of your information is of the utmost importance. Your card information is stored by the credit card merchant vendor, who specializes in credit card processing and maintains the highest level of security for credit information. Our staff does not have access to your card information after it is entered into the merchant vendor's database. No personal medical information is stored with the credit merchant company.

**If you have any questions about the financial policy please contact our business office at 913-541-0510.**

***I have read and understand the policies stated above and agree to them, as described.  
I understand that this agreement is final and irrevocable.***

\_\_\_\_\_  
**Patient Name (printed)**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**