



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
- Erin Anderson, 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 #:
<i>Policy Holder's Name:</i>	<i>Relationship:</i>	<i>DOB:</i>
Claims Mailing Address:		

<u>Secondary Insurance:</u>	Member ID:	Group #:
<i>Policy Holder's Name:</i>	<i>Relationship:</i>	<i>DOB:</i>
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, 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.

<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 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

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

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

Recreational Drug Use:

Never Currently Using IV drugs Used IV drugs in the past

Gastrointestinal Assoc., 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 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. Our office does not guarantee benefits of your insurance policy. Benefits will be determined, by your insurance company, after they receive our claim. 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, and major credit cards. 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.

Screening colonoscopies are considered a preventative service and covered by most insurance companies at 100%.

However, there are strict guidelines, set by your insurance policy, regarding what is considered a screening colonoscopy.

This includes factors such as personal and family medical history, active symptoms or other colon cancer risk factors. You can find more information and FAQ's regarding screening, surveillance and diagnostic colonoscopy, on our website, **kc-gi.com**. Look for the section titled **"What You Need to Know about Colonoscopy and Insurance Benefits"**.

Our office does not offer long term financing of balances for 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 pays. 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. 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 Assoc., 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 Assoc, 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 Assoc, LLC personnel. I understand that I am responsible for all charges for services that I receive from Gastrointestinal Assoc, 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 Assoc, 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/debit 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)

Date of Birth

Signature

Date