

# Gastroenterology Associates

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Pear M. Enam, MD, FACP • Rashid Hanif, MD, FACP • C.P. Choudari, MD, MRCP

## Office Information:

Your initial visit is for an office consultation only. The medical necessity of any other procedure such as upper endoscopy, colonoscopy or other diagnostic test will be determined at the consultation. **There is no special preparation for this office visit.** Please arrive 15 minutes early for your first appointment.

We are implementing an electronic medical record. Unfortunately, you may experience some delays. We appreciate your patience as we work toward more efficient patient care.

Our office is located at:

11110 Medical Campus Road  
Suite 250 (Silver Entrance)  
Hagerstown, MD 21742  
301-733-4404

## Please bring the following with you to your office consultation:

- ✓ Attached patient information, **completed and signed prior to arrival**. If paperwork is not completed by your appointment time, your appointment will be rescheduled.
- ✓ Insurance, Medicare or Medical Assistance cards
- ✓ Insurance **referral form**; if necessary. (Many primary physicians will not fax these.)
- ✓ Medical records, if so instructed by your primary physician
- ✓ Current medication containers / bottles
- ✓ Your calendar, this will help you schedule a time for any testing / procedure the doctor may order.
- ✓ Photo identification (in response to federally mandated standards). **If your address differs from that which is printed on your driver's license or other photo ID, please bring a utility bill or other correspondence that shows your name and correct address.**

Co-payments and Medicare's Co-insurance are collected on the date of service prior to your office visit. **If you are unable to make this payment, your appointment will be rescheduled.**

After your initial visit, if you are having a medical problem or need assistance, we request that you call the office between 8:00 a.m. and 3:30 p.m. It is very difficult for us to accommodate walk-in patients. Walk-in patients may be charged a fee of \$45.00 for a visit with the nurse.

**Cancellations and rescheduled visits.** Appointment times have been reserved for you. We request that you cancel or reschedule your office appointment or endoscopic procedure by phone a minimum of 2 business days in advance. This will give us ample time to fill those appointments with patients who need to be seen. There may be a charge of \$25.00 for no show appointments and cancelled or rescheduled appointments without proper notice. Failure to show up for an endoscopic procedure may result in a charge of \$75.00. This fee is not billable to your insurance company. **Multiple cancellations, reschedules or no show appointments may result in your discharge from our practice.**

Please take a few minutes and visit our web site at: [www.gidoc.biz](http://www.gidoc.biz).

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## **Notice of Privacy Practices**

Effective April 14, 2003

*To our patients.* This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### ***Our commitment to your privacy***

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

### ***Use and disclosure of your health information in certain special circumstances***

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

### ***Your rights regarding your health information***

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Jean Gross, Office Manager.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Jean Gross, Office Manager. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Jean Gross, Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Jean Gross, Office Manager, 301-733-4404.

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## Registration Information

<b>Patient Name: Last/First/Initial</b>		
Address: Street		
City, State, Zip		
<b>Referring Doctor:</b>		
<b>Primary Doctor:</b>		
Email address:		
Patient's Sex:	Male	Female
Patient's Date of Birth:		
<b>Patient's Phone #s:</b>	<b>Home #:</b>	<b>Cell #:</b>
Patient's Work #:		
Patient's Social Security #:		

<b>Primary Insurance:</b>		
Subscriber's Name:		
Subscriber's Birthdate:		
Employer Name/Address:		
<b>Second Insurance:</b>		
Subscriber's Name:		
Subscriber's Birthdate:		
Employer Name/Address:		

## **ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with:

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Name of Insurance Company

and assign directly to Gastroenterology Associates medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

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Signature of Insured/Guardian

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Date

## **MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made on my behalf to Gastroenterology Associates for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

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Medicare Subscriber Signature

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Date

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## CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, \_\_\_\_\_, hereby authorize 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 health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Gastroenterology Associates can refuse to treat me.

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

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

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

I understand that I have the right to request that Gastroenterology Associates restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Gastroenterology Associates does not have to agree to such restrictions, but that once such restrictions are agreed to, they must adhere to such restrictions.

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***Signature of patient or patient's representative***

***Date***

*(Form MUST be completed before signing.)*

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**Printed name of patient or patient's representative**

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**Relationship to the patient**

## Payment Policy

- \* Co-payment and/or co-insurance is due at the time of service. For your convenience we accept cash, Debit Cards, checks, VISA, MasterCard and Discover.
- \* Our office will submit claims for payment for office visits, in-patient hospital visits, endoscopic procedures and other medically related services to most insurance companies. We participate with many insurances and are contracted to accept their payment as payment in full. Co-payments, deductibles and services not covered by your insurance company are the responsibility of the patient. Please check with the receptionist regarding our participation with your insurance company. If we do not participate with your insurance company, we will submit the claims as a courtesy to you and will bill you for the balance.
- \* HMO and Managed Care plans require referrals for services. If you do not have a valid referral on the day of your appointment, you will be asked to reschedule your appointment or pay for all charges at the time of service.
- \* If a response is not received from the insurance company within sixty (60) days of billing, the balance will become the patient's responsibility.

**I understand and agree that I am ultimately responsible for the balance on my account for professional services rendered since I, or my dependent, received the health care. I have read, understand and agree to all the terms described in the Payment Policy above.**

\_\_\_\_\_  
Patient's / Responsible  
Party's Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Today's Date:

\_\_\_\_\_  
Date of Birth:

Consult requested by Dr. \_\_\_\_\_ for \_\_\_\_\_

## Race

White/Caucasian  Black or African American  Asian  Hispanic or Latino  
 American Indian or Alaska Native  Native Hawaiian or Other Pacific Islander  Mixed  Other  
 Unknown  Patient declines to provide information

## Ethnicity

Hispanic or Latino  Not Hispanic or Latino  Patient declines to provide information

## Preferred Language

English  Spanish  Other \_\_\_\_\_

## Contact Preference

Home phone / voice mail  Work phone / voice mail  Cell phone / voice mail

Allergies  No Known Drug Allergies Are you allergic to Latex? Yes / No

I am allergic to: \_\_\_\_\_

## Current Medications

<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>
1.		10.	
2.		11.	
3.		12.	
4.		13.	
5.		14.	
6.		15.	
7.		16.	
8.		17.	
9.		18.	

**Diagnostic Studies / Tests**

Tests:	Where / When
Colonoscopy	
Upper Endoscopy (EGD)	
Blood Tests	
CAT Scan	
EKG	
Liver Biopsy	
Stool Occult Blood Test	
Ultrasound	
X-Rays	
Other:	

**Previous Procedures** - Please indicate any of the following procedures or surgeries you have had: NONE

Appendectomy – When: \_\_\_\_\_

Heart Bypass – When: \_\_\_\_\_

Cardiac Stents – When: \_\_\_\_\_

Pace Maker – When: \_\_\_\_\_

Defibrillator – When: \_\_\_\_\_

Stomach/Bowel/Colon – When: \_\_\_\_\_

Gallbladder Removed: When \_\_\_\_\_

Uterus/Tubes/ Ovaries – When \_\_\_\_\_

Gastric Bypass – When: \_\_\_\_\_

Other procedures / surgeries not listed above: \_\_\_\_\_

**Past or Present Medical Conditions**

Please circle the conditions **you** currently experience or have had in the past: NONE

- |                     |                              |             |                     |                 |                      |
|---------------------|------------------------------|-------------|---------------------|-----------------|----------------------|
| Anemia              | Angina/Chest Pain            | Anxiety     | Arthritis           | Asthma          | Cholesterol Problems |
| Colitis             | Colon Polyps                 | COPD        | Crohn’s Disease     | Depression      | Diabetes             |
| Disease of Pancreas | Emphysema                    | Esophagitis | Gallbladder Disease | GERD            | Heart Attack         |
| Heart Disease       | Hemorrhoids                  | Hepatitis   | High Blood Pressure | HIV/AIDS        |                      |
| Irregular Heartbeat | Irritable Bowel Syndrome/IBS | Jaundice    | Kidney Disease      | Liver Disease   |                      |
| Rheumatic Fever     | Seizure Disorder             | Sleep Apnea | Stroke              | Thyroid Disease | TIA    Ulcers        |

**Social History**

Occupation: \_\_\_\_\_

Marital Status:    Single    Married    Divorced    Separated    Widowed    Civil Union    Unknown    Other

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

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**Alcohol** \_\_\_ None

Type	Amount	Frequency
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Type	Amount	Frequency
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**Caffeine** \_\_\_ None

Type	Amount	Frequency
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Type	Amount	Frequency
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**Tobacco**

Smoking Status

\_\_\_ Current every day smoker   \_\_\_ Current some day smoker   \_\_\_ Former smoker   \_\_\_ Never smoker  
 \_\_\_ Smoker, current status unknown   \_\_\_ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
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**Drug Use** \_\_\_ None

\_\_\_ Used IV drugs in the past   \_\_\_ Used other drugs in the past   \_\_\_ Use recreational drugs now

**Family Medical History** \_\_\_ No Knowledge of family history

Do you have a family history of: Celiac Sprue Yes / No      Colon Cancer Yes / No  
 Colon Polyps Yes / No      Inflammatory Bowel Disease Yes / No  
 Liver Disease Yes / No      Ulcer problems Yes / No

Diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
<b>FAMILY HISTORY</b>										
Celiac Disease										
Colon Cancer										
Colon Polyps										
Inflammatory Bowel Disease										
Liver Disease										
Stomach problems / ulcers										
Gallbladder problems										
Pancreas problems										
Heart Disease										

<p><b><u>CARDIOVASCULAR</u></b></p> <p>_____ None                  Y / N Chest pain                  Y / N Palpitations                  Y / N Shortness of breath                  Y / N Swelling of ankles / feet</p> <p><b><u>CONSTITUTIONAL</u></b></p> <p>_____ None                  Y / N Fatigue                  Y / N Fever                  Y / N Weight gain                  Y / N Weight loss                  Y / N Problems with anesthesia                    or                    sedation</p> <p><b><u>EARS/NOSE/THROAT/MOUTH</u></b></p> <p>_____ None                  Y / N Hearing loss                  Y / N Mouth sores                  Y / N Ringing in ears</p> <p><b><u>ENDOCRINE</u></b></p> <p>_____ None                  Y / N Excessive thirst                  Y / N Excessive urination                  Y / N Cold intolerance                  Y / N Heat intolerance</p> <p><b><u>EYES</u></b></p> <p>_____ None                  Y / N Blurred vision                  Y / N Glaucoma</p>	<p><b><u>GASTROINTESTINAL</u></b></p> <p>_____ None                  Y / N Abdominal pain                  Y / N Belching                  Y / N Black, tarry stools                  Y / N Bloating                  Y / N Blood in stool                  Y / N Change in bowel habits                  Y / N Constipation                  Y / N Diarrhea                  Y / N Difficulty swallowing                  Y / N Heartburn                  Y / N Nausea                  Y / N Poor appetite                  Y / N Rectal bleeding                  Y / N Regurgitation                  Y / N Stomach cramps                  Y / N Vomiting</p> <p><b><u>GENITOURINARY</u></b></p> <p>_____ None                  Y / N Burning with urination                  Y / N Blood in urine                  Y / N Are you or could you possibly                  be pregnant?</p> <p><b><u>HEMATOLOGIC/ LYMPHATIC</u></b></p> <p>_____ None                  Y / N Anemia                  Y / N Blood transfusion in the past                  Y / N Easy bruising                  Y / N Prolonged bleeding</p>	<p><b><u>SKIN</u></b></p> <p>_____ None                  Y / N Itching                  Y / N Rashes</p> <p><b><u>MUSCULOSKELETAL</u></b></p> <p>_____ None                  Y / N Back pain                  Y / N Joint pain                  Y / N Joint swelling                  Y / N Muscle pain                  Y / N Muscle weakness</p> <p><b><u>NEUROLOGICAL</u></b></p> <p>_____ None                  Y / N Frequent headaches                  Y / N Numbness or tingling                  Y / N Seizures                  Y / N Stroke</p> <p><b><u>PSYCHIATRIC</u></b></p> <p>_____ None                  Y / N Anxiety                  Y / N Depression                  Y / N Memory loss or confusion</p> <p><b><u>RESPIRATORY</u></b></p> <p>_____ None                  Y / N Coughing                  Y / N Spitting up blood                  Y / N Wheezing</p>
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**Pharmacy**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**If necessary, your medical information can be released to someone other than yourself. Please list names of authorized people:**

Spouse: \_\_\_\_\_ Yes \_\_\_\_\_ No

Parent: \_\_\_\_\_ Yes \_\_\_\_\_ No

Other Names: (Please list relationship such as daughter, son, boyfriend, girlfriend, fiancé, sister, etc.)

**Patient Signature - All information contained on these patient history forms is true and correct to the best of my belief.**

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