GASTROENTEROLOGY ASSOCIATES

Patient Registration

(PLEASE PRINT CLEARLY!)

Patient's Name:_____ SS #: _____
First Name MI Last Name

Date of Birth:_____ Male Female _Single _Married _Widowed Divorced _Separated

Mailing Address:_____

City/State/Zip Code:_____ Home Phone w/Area Code:_____

Cell phone w/ area code:_____ Email:_____

Spouse's Name:_____

Spouse's Employer:_____ Spouse's Work Phone#:_____

Patient's Employer:_____ Work Phone w/Area Code:_____

In case of emergency, please contact_____

Contact number:_____ Relationship:_____

Is this work-related? _Yes _No **We do not participate in Workers Compensation**

Primary Care Physician's Name & Phone Number:_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR SCANNING INTO YOUR MEDICAL RECORD

If you do not have insurance, have you applied for Medicaid? __Yes _No

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I hereby authorize the payment of medical benefits to Gastroenterology Associates for services rendered. I understand that Iam financially responsible for any services not covered by my insurance carrier.

I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.

I hereby authorize Gastroenterology Associates to release any medical information necessary to complete and process my insurance claims.

I authorize Gastroenterology Associates to treat me and use my personal health information for healthcare operations.

Patient/Guarantor Signature_____ Date_____

GASTROENTEROLOGY ASSOCIATES

4367 NW AMERICAN LANE
LAKE CITY, FLORIDA 32055
(386) 758-6094
(386) 243-8152

NAME_____ DATE_____

REASON FOR VISIT_____

_____

DRUG ALLERGIES (PLEASE LIST REACTIONS)_____

_____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING. IF YOU BROUGHT A MEDICATION LIST WITH YOU, PLEASE TURN THAT IN UPON COMPLETION OF YOUR PAPERWORK. ALSO, BE SURE TO INCLUDE OVER THE COUNTER MEDICATIONS AS WELL AS ANY NUTRITIONAL SUPPLEMENTS.

NAME & STRENGTH	FREQUENCY

-IF YOU NEED MORE SPACE, PLEASE SEE THE RECEPTIONIST AT THE FRONT DESK-

PROCEDURE/SURGICAL HISTORY

(PLEASE FILL IN AND CIRCLE THE APPROPRIATE ANSWERS)

UPPER ENDOSCOPY:

DATE:_____ DOCTOR:_____ FACILITY:_____

COLONOSCOPY:

DATE:_____ DOCTOR:_____ FACILITY:_____

POLYPS REMOVED? YES NO

COLON RESECTION: LEFT RIGHT **REASON FOR RESECTION:** COLON CANCER DIVERTICULITIS

HEART STENTS: HOW MANY:_____

DATE:_____ DOCTOR:_____ FACILITY:_____

HYSTERECTOMY: PARTIAL COMPLETE

GALLBLADDER CATARACT APPENDIX GASTRIC BYPASS HEMORRHOID

INGUINAL HERNIA VENTRAL HERNIA UMBILICAL HERNIA LIVER TRANSPLANT KIDNEY TRANSPLANT

KNEE REPLACEMENT HIP REPLACEMENT TONSILS ADENOIDS ILEOSTOMY

PERSONAL HEALTH HISTORY

(PLEASE FILL IN AND CIRCLE THE APPROPRIATE ANSWERS)

Does anyone in your family have a history of colon cancer? YES NO

If yes, whom?_____
(Please include the relationship)

Do you smoke cigarettes? YES NO If yes, how many per day?_____Per week?_____

Do you drink alcoholic beverages? YES NO If yes, what type?_____

How often?_____How many drinks?_____

Do you use illicit drugs? YES NO If yes, what type?_____

CURRENT HEALTH CONDITIONS

(PLEASE CIRCLE **ONLY** THE SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING)

GENERAL: APPETITE LOSS FATIGUE FEVER WEIGHT LOSS ANOREXIA

SKIN: SKIN LESIONS PRURITUS (ITCHY SKIN) RASH

HEENT: VISION LOSS DIZZINESS NOSE BLEED SORE THROAT VOICE CHANGES

RESPIRATORY: DIFFICULTY BREATHING CHRONIC COUGH COUGHING UP BLOOD WHEEZING

CARDIO: CHEST PAIN DIFFICULTY BREATHING LYING DOWN SWELLING OF ARMS/LEGS
FAINTING BLACKING OUT PALPATATIONS SHORTNESS OF BREATH

GASTRO: ABDOMINAL PAIN BLOATING BLOODY STOOL CHANGE IN BOWEL HABITS
INCONTINENCE OF STOOL NAUSEA VOMITING VOMITING BLOOD
HEARTBURN PAINFUL OR DIFFICULTY SWALLOWING JAUNDICE

FEMALE: BLOOD IN URINE PAINFUL URINATION FLANK PAIN NIPPLE DISCHARGE

MUSCULOSKELETAL: MUSCLE PAIN SWELLING OF EXTREMITIES

NEUROLOGICAL: SEIZURES VISUAL CHANGES MUSCLE TWITCHING

PSYCHIATRIC: ANXIETY DEPRESSION MOOD CHANGES THOUGHTS OF SUICIDE

ENDOCRINE: APPETITE CHANGES COLD INTOLERANCE HEAT INTOLERANCE

HEMATOLOGY: ABNORMAL BLEEDING EASY BRUISING EASY BLEEDING
PROLONGED BLEEDING SPONTANEOUS BLEEDING

SIGN X_____DATE_____

GASTROENTEROLOGY ASSOCIATES
Billing Policy

The following sets forth the general billing policy of Gastroenterology Associates. Please review this information and sign where indicated.

•• I understand that it is my responsibility to provide the office of Gastroenterology Associates with current, accurate billing information at the time of check in and to notify office of any changes in this information.

•• **I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered.** I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

•• I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, money order, cashier's check, or credit card.

•• I understand that there is a $20 fee to complete disability paperwork, Aflac or any other types of forms that require physician review and signature. **I understand that the $20 fee prior to completion.**

•• I understand the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further runderstand that **THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.**

•• I understand that I will be balance billed for any remaining fees after my insurance has processed the claim and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

•• I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

•• I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to cancelling your appointment. Failure to do so may result in a $50.00 fee per occurrence. I understand that if I no show for 2 consecutive appointments or no show for a total of 3 appointments, not only will I be charges a $50.00 no show fee, I may be discharged from care. You will be notified in writing via certified mail if you are discharged from care.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the physicians of Gastroenterology Associates.

_____ _____

Patient Name Date

_____

Patient Signature

GASTROENTEROLOGY ASSOCIATES OF NORTH FLORIDA

Credit Card Pre-Authorization

In an effort to better serve our patients we require a charge card on file. Charge card information is filled with our merchant provider and privacy measures are current with all PCI and Federal regulations to ensure your information is kept secure.

POLICY

_____I understand my credit card information is being requested because my physician's office has a 24 hour No Show and Cancellation Policy. In the event I cancel within 24 hours of my appointment or I No Show my appointment I will be charged a $50 fee.

_____Being the authorized cardholder or the Corporate Officer, by signing this consent I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize Gastroenterology Associates of North Florida to charge my credit card for failure to comply with office policy. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request.

PAYMENT INFORMATION

Name: _____

Billing Address: _____

_____

Type of Card: ☐ VISA ☐ MasterCard ☐ American Express ☐ DISCOVER

Card Number: _____

Expiration Date: _____ Security Code: _____
(last three digits on card, last four on AMEX)

The undersigned guarantees performance of the financial provisions of this agreement.

Card Holder Name: _____

Signature of Card Holder: _____ Date: _____

Gastroenterology Associates
4367 NW American Lane
Lake City, FL 32055
(386) 758-6094 phone
(386) 243-8152 fax

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient's SSN: _____

The information covered in this authorization form includes medical mail outs, lab test results, pertinent medical information, and account status.

Purpose of Disclosure: Account Status / Lab Test Results / Health Information
Other Uses of Disclosure: You have the right to request restriction of use and disclosure of your health information for any purpose other than those listed in the "Notice of Privacy Policy." You may write a letter of revocation at any time to change your original authorization with the understanding it does not affect any release of information prior to the revocation or termination of this authorization must be submitted to Physicians Care in writing, followed by a phone call to verify it was received and changed.
Potential for Re-Disclosure: Information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Once we disclose this information to another party it becomes their responsibility to protect your right to privacy.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please list name of persons to whom medical information can be disclosed:

_____

_____

List any restrictions regarding your medical information.

_____

Please complete the following information on ways we may contact you regarding treatment, test results, or status of your account?

Home: _____ Voice Mail? Yes No

Cell Phone: _____ Voice Mail? Yes No

Home Address: _____

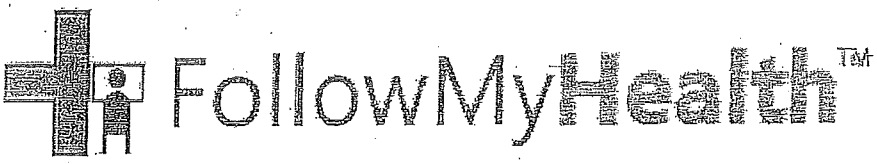
I have received / been offered a copy of "Notice of Privacy Practices" and give authorization for use / disclosure of my health information.

Print Patient Name: _____

Signature of Patient: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

PATIENT NAME:_____



GASTROENTEROLOGY ASSOCIATES OF NORTH FLORIDA
PATIENT EDUCATION FOR ONLINE ACCESS TO EPHI

How to Request Online Access to Your Medical Chart with GAONF

- With your most recent encounter with your doctor at our office, she or he has discussed with you the possibility of receiving access to your health record online with our office through or "Follow My Health" patient portal.
- The web address for Gastroenterology Associates "Follow My Health" portal is gaonf.followmyhealth.com
- If you would like to have access to your health records with our office, please stop-by in person (we'd prefer to walk you through the process in person), or call the office at 386-758-6094 and ask a receptionist to send you an electronic invitation to your email address.
- If you would prefer to wait, contact us later, or decline online access currently to your health records with our office, remember that you can contact us at any time to set-up.

Account Creation Process

- You will receive an email from "Follow My Health," in which it will have a link that you click on to create an account (you will be prompted to create an username and password).
- Once your account is created, "Follow My Health" will prompt you to log-in. Log-in to your account.
- When logging in for the first-time, you will be met with a welcome message, along with consents and agreements that you must accept. Read these consents and agreements thoroughly and ensure your understanding of them.
- During the first time log-in process, you will be prompted for an "Invitation Code." Your invitation code will be your year of birth e.g. "1954." It will be the four digit year of birth, and nothing else.
- Once the invitation code is validated, your account will automatically begin to link with our Electronic Medical Record system, and then it will automatically populate your "Follow My Health" account home-page.
- You are now successfully inside your GAONF "Follow My Health" portal account. Watch the "First Time Walk-Through" to familiarize yourself with the account's numerous functions. Feel free to call our office with any questions at 386-758-6094.

Accept Online Access	Decline Online Access
Sign:_____	Sign:_____
Date:_____	Date:_____

EMAIL:_____