





Advanced Gastroenterology PLLC  
Advanced Endoscopy Center PLLC

### Insured Patient Payment Policy

**Patient Responsibility:**

- You are responsible for all charges resulting from treatment provided by Advanced Gastroenterology. We bill most insurance carriers. However, primary responsibility for the account is yours. Your co-payment is always due at the time of service; any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us.
- Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

**Insurance Billings:**

- It is your responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.
- Medicare: We participate with Medicare. We will bill Medicare as your primary insurer. We will also bill your supplemental insurance provider.
- Medicaid: Please bring your current medical card with you to each appointment.

**Check Returned:**

*It is our office policy to charge a \$35 fee for checks that are returned due to non-sufficient funds.*

**Authorization to Release Information:**

- In obtaining payment for services, I authorize my healthcare provider, Advanced Gastroenterology to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including but not limited to: my insurance companies and their representatives, and my employer or union if they are involved in processing the claim. *For further information regarding disclosure of health information, please refer to the Notice of Privacy Information Practices available in our office.*
- If I have been referred by, or am referred to another healthcare provider, I authorize Advanced Gastroenterology to release my medical information to this provider for continuing care.
- I also assign Advanced Gastroenterology all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by my insurance provider or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

**I, or my appointed agent, have read, fully understand, and agree to the above statements. I can request a copy of this policy at any time.**

Patient's Name (please PRINT)	Patient's Signature	Date

**If the patient is under the age of 18 years, or is otherwise unable to sign, complete the following:**

Patient is \_\_\_\_\_ year(s) of age or is unable to sign because: \_\_\_\_\_

Patient's Name (please PRINT)	Guarantor's Signature	Date
Date		

**Sign below if disclosure of information is NOT authorized:**

Therefore, I agree to pay for costs of all treatment and services personally.

Patient's Name (please PRINT)	Patient's Signature	Date

HEALTH HISTORY-TO BE COMPLETED BY PATIENT

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Please Print

REASON FOR VISIT: \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_

Medical Problems- Please indicate if you are *currently* experiencing any of the following:

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Colon cancer    | <input type="checkbox"/> Heartburn                | <input type="checkbox"/> Kidney stones          | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Colon polyps    | <input type="checkbox"/> Hepatitis – Type _____   | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hiatal hernia            | <input type="checkbox"/> Pancreatitis           |   |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Depression      | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Parkinson's disease    |   |
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Rheumatic fever        |   |
| <input type="checkbox"/> Chronic cough        | <input type="checkbox"/> Diverticulosis  | <input type="checkbox"/> Irregular heart beat     | <input type="checkbox"/> Seizure                |   |
| <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Fibromyalgia    | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Stomach/duodenal ulcer |   |
| <input type="checkbox"/> Cirrhosis of liver   | <input type="checkbox"/> Gallstones      | <input type="checkbox"/> Kidney disease/failure   | <input type="checkbox"/> Stroke/paralysis       |   |

Surgeries/Procedures- Please indicate if you have *previously* had a surgery or procedure:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> <b>NONE</b>                | <input type="checkbox"/> Endoscopy (EGD) – Date: _____ | <input type="checkbox"/> Obesity surgery |
| <input type="checkbox"/> Appendectomy               | <input type="checkbox"/> Esophageal Manometry/pH study | <input type="checkbox"/> Prostate        |
| <input type="checkbox"/> Breast surgery-KIND: _____ | <input type="checkbox"/> Gallbladder surgery           | <input type="checkbox"/> Stomach         |
| <input type="checkbox"/> Cardiac surgery            | <input type="checkbox"/> Hiatal hernia surgery         | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Colon resection            | <input type="checkbox"/> Hemorrhoidectomy              | <input type="checkbox"/> Tonsillectomy   |
| <input type="checkbox"/> Colostomy                  | <input type="checkbox"/> Hysterectomy                  | <input type="checkbox"/> Tubal ligation  |
| <input type="checkbox"/> C-Section                  | <input type="checkbox"/> Joint replacement             | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Colonoscopy – Date: _____  | <input type="checkbox"/> Liver biopsy                  |  |

Social History:

Marital Status:  Single  Married  Divorced  Widow

Current Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Do you currently smoke? \_\_\_\_\_ If you've smoked previously, when did you stop? \_\_\_\_\_

How many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How many drinks per day? \_\_\_\_\_ per week? \_\_\_\_\_ per month? \_\_\_\_\_

Do you use illicit drugs? \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

Family History:

History of Heart Disease (heart attack, heart failure)?  Yes  No who: \_\_\_\_\_

History of Strokes?  Yes  No who: \_\_\_\_\_

History of High blood pressure?  Yes  No who: \_\_\_\_\_

History of Diabetes?  Yes  No who: \_\_\_\_\_

History of Cancer?  Yes  No Type: \_\_\_\_\_ who: \_\_\_\_\_

History of Crohn's disease or ulcerative colitis?  Yes  No who: \_\_\_\_\_

Other: \_\_\_\_\_

(cont)

**Allergies:** *NONE* Aspirin Morphine Penicillin Sulfa Versed Valium Other: \_\_\_\_\_

**GI Medications-** Please indicate if you are ***currently*** taking any of the following: ***NONE***

Aciphex	Axid	Entocort	Levsin	NuLev	Prednisone	Rowasa
Amitiza	Bentyl	Hyoscyamine	Lialda	Nexium	Prevacid	Tagamet
Anusol	Carafate	Lactulose	Lomotil	Pentasa	Prilosec	Zantac
Asacol	Donnatal	Levbid	Miralax	Pepcid	Protonix	

**Other Medications-** Please include the **STRENGTH & DOSAGE:**

**Review of Systems-** Please indicate if you are ***currently*** experiencing the following:

**General:**  fevers,  chills,  sweats,  anorexia,  fatigue,  malaise,  weight loss

**Eyes:**  blurring,  diplopia (double vision),  irritation,  discharge,  vision loss,  eye pain

**Ears/Nose/Throat:**  earache,  ear discharge,  tinnitus (ringing in ear),  decreased hearing,  nasal congestion,  nosebleeds,  sore throat,  hoarseness,  dysphagia (difficult swallowing)

**Cardiovascular:**  chest pains,  palpitations,  syncope (passing out),  dyspnea on exertion (shortness of breath),  orthopnea (shortness of breath when lying down),  peripheral edema (leg swelling)

**Respiratory:**  cough,  dyspnea (shortness of breath),  excessive sputum,  hemoptysis (coughing up blood),  wheezing

**Gastrointestinal:**  nausea,  vomiting,  diarrhea,  constipation,  change in bowel habits,  abdominal pain,  melena (black stool),  hematochezia (rectal bleeding),  jaundice (yellow skin)  heart burn

**Genitourinary:**  vaginal discharge,  incontinence,  dysuria (painful urination),  hematuria (bloody urination),  urinary frequency,  amenorrhea (no menstruation),  menorrhagia (heavy menstruation),  abnormal vaginal bleeding,  pelvic pain

**Musculoskeletal:**  back pain,  joint pain,  joint swelling,  muscle cramps,  muscle weakness,  stiffness,  arthritis

**Skin:**  rash,  itching,  dryness,  tattoo

**Neurologic:**  transient paralysis,  weakness,  seizures,  syncope (passing out),  tremors,  vertigo

**Psychiatric:**  depression,  anxiety,  memory loss,  suicidal ideation,  hallucinations,  paranoia

**Endocrine:**  cold intolerance,  heat intolerance,  polydipsia (excessive thirst),  polyuria (excessive urination)

**Heme/Lymphatic:**  abnormal bruising,  bleeding,  enlarged lymph nodes

**Allergic/Immunologic:**  urticaria (itching),  hay fever,  HIV exposure,  eczema