

WELCOME BACK

NAME: _____ DATE: _____

Please take a moment to complete this information. This will ensure our records are accurate and your physician will have the most up to date information.

Referring Doctor _____ Primary Care _____

Current GI problems or complaint: _____

Please indicate if you are currently experiencing any of the following:

| | |
|-------------------------------------|---------------------------|
| Weight loss _____ lbs | Weight Gain _____ lbs |
| Fever _____ | Shortness of breath _____ |
| Cough _____ | Chest Pain _____ |
| Nausea _____ | Vomiting _____ |
| Difficulty swallowing _____ | Diarrhea _____ |
| Constipation _____ | Rectal Bleeding _____ |
| Blood in Stool _____ | |
| Abdominal Pain _____ Location _____ | |

Are you here as a follow up to a GI study, procedure, or Hospitalization:

Were you informed of the results before today: _____

New drug allergies since last visit: _____

Current Medications (including dose, frequency, and over-the counter medications)

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Any new medical problems or complaints:

Have you had any test or procedures done by other doctors since your last visit:

**CENTER FOR DIGESTIVE HEALTH / ENDOSCOPY
FINANCIAL POLICY AND PATIENT RESPONSIBILITY STATEMENT:**

Payment for all services rendered by Center for Digestive Health/Endoscopy are due at the time of service unless other arrangements are made in advanced or we have a contract with your insurance plan.

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Center for Digestive Health/Endoscopy for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Patient, Parent or Guardian Signature (if child is under 18 years of age)

Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Center for Digestive Health/Endoscopy for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract, such as any deductible, co-payment, co-insurance, non-covered services, or services rendered if my insurance is terminated. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient, Parent or Guardian Signature (if child is under 18 years of age)

Date

Patient's Rights and Responsibilities, HIPAA Privacy Practices, and Advanced Directives Acknowledgement of Receipt:

I, the undersigned acknowledge receipt of the document titled Patient's Rights and Responsibilities, HIPAA Privacy Practices, and Advanced Directives.

Patient, Parent or Guardian Signature (if child is under 18 years of age)

Date

MEDICAL RECORDS RELEASE:

I hereby grant permission to Center for Digestive Health/Endoscopy to release medical information to my insurance carrier(s) in response to their request for information required to file a claim for reimbursement on MY or PATIENT'S behalf.

SIGNED: _____ (PATIENT OR GUARDIAN)

DATE: _____

This is to authorize the verbal release of my medical condition, status, and/or test results, in the event that I am not home, to the following (specify all family members authorized):

Signature

Date

No expiration on authorization unless specified by patient