Associates in Gastroenterology, P.C.
14010 Smoketown Rd., Suite 117
Woodbridge, Virginia 22192
703-580-0181

Patient's Name:	DOB:	Today's Date:
Primary Physician:		
Referring Physician:		

Reason for your visit:

____

____

____

Current Medicines: (name and dose) ** AIG can only refill medications prescribed by our office*

1.	Refill Needed:	7.	Refill Needed: Y N
2.	Refill Needed: Y N	8.	Refill Needed: Y N
3.	Refill Needed: Y N	9.	Refill Needed: Y N
4.	Refill Needed: Y N	10.	Refill Needed: Y N
5.	Refill Needed: Y N	11.	Refill Needed: Y N
6.	Refill Needed: Y N	12.	Refill Needed: Y N

Personal Medical History:

□ Acid Reflux	□ Colitis	□ Hepatitis	□ Osteoporosis
□ Alcoholism	□ Depression	□ High blood pressure	□ Stroke
□ Anemia	□ Diabetes	□ High cholesterol	□ Substance abuse
□ Anorexia/bulimia	□ Diverticulosis	□ HIV	□ Thyroid disease
□ Arthritis/gout	□ Emphysema	□ Irritable bowel	□ Tuberculosis
□ Asthma	□ Epilepsy/seizures	□ Kidney disease	□ Ulcers (stomach)
□ Blood clots	□ Gallstones	□ Liver disease	□ Ulcerative colitis
□ Cancer	□ Heart disease	□ Lung disease	□ Uterine bleeding
□ Crohn's Disease	□ Heart arrhythmia	□ Mental illness	
Others (please provide details):			

Medication allergies or reactions: (name and type of reaction)

1.
2.

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Patient's Name: ________________________________ Today's Date: ______________

Previous GI Procedures (year, results, doctor's name):

Colonoscopy:
Sigmoidoscopy:
Upper Endoscopy (EGD):
Video Capsule studies (Pillcam):

Previous Surgeries (type and year):

1.
2.
3.
4.
5.
6.

Previous Hospitalizations (diagnosis or reason, year, which hospital):

1.
2.
3.

Family Medical History:

Check (√) and provide details:	Medical details about your family (diseases, types of cancer, etc.):
☐ Colon cancer/polyps	Father:
	Mother:
☐ Crohn's disease, ulcerative colitis	Siblings:
☐ Liver disease or hepatitis	
☐ Pancreatic cancer	Children:
☐ Gall bladder disease	Paternal grandfather:
☐ Stomach or esophagus cancer	Paternal grandmother:
☐ Diabetes	Maternal grandfather:
☐ Coronary artery disease	Maternal grandmother:

Personal Information:

Marital status:
Occupation:
Alcohol use:
Tobacco use:
Country of birth:

ADVANCED DIGESTIVE CARE

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Patient's Name: ___________________________________ Today's Date: ________________

Review of Symptoms:
Do you currently have any of these symptoms?

General:
- □ Change in general health
- □ Change in strength/stamina
- □ Fevers/sweats

Endocrine:
- □ Unusual change in weight
- □ Fatigue/lethargy
- □ Change in appetite

Heart and Circulation:
- □ Chest pain
- □ Palpitations
- □ Swelling in legs

Lungs:
- □ Cough
- □ Shortness of breath
- □ Wheezing

Neurologic:
- □ Headache
- □ Poor balance
- □ Tingling in fingers/toes

Muscles/ Bones:
- □ Joint aches
- □ Muscle weakness/pain

Mood:
- □ Anxiety/depression
- □ Poor sleep
- □ Difficulty concentrating

Allergy:
- □ Hives/swelling
- □ Allergic reaction to medicine

Eyes:
- □ Change in vision
- □ Eye pain

Ears, Nose, Throat:
- □ Hearing loss
- □ Nose bleeds
- □ Sore throat/voice changes

Skin:
- □ Rash
- □ Discoloration
- □ Hair Loss

Genito-Urinary:
- □ Difficulty urinating
- □ Blood in urine
- □ Change in sexual function

Stomach/ Intestines/ Digestion:
- □ Nausea
- □ Vomiting
- □ Heartburn
- □ Abdominal pain
- □ Difficulty swallowing
- □ Bloating/gas
- □ Blood in stool
- □ Change in bowel habits
- □ Diarrhea
- □ Constipation
- □ Belching
- □ Rectal bleeding
- □ Abnormal bowel sounds
- □ Hemorrhoids

Other:
- □ ________________

□ **Please check this box, IF, In the event wait times are prolonged, are you willing to have the available PA/NP start your visit to expedite your care?**

ADVANCED DIGESTIVE CARE

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Patient Registration

Last Name:	First Name & M.I.:	Date of Birth:	Sex: M F
Address:			
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Social Security Number:		Email: Do we have permission to email you? Y N	

Primary Care Physician name:	Phone No:	Fax No:
Referring Physician name:	Phone No:	Fax No:
Preferred Pharmacy name:	Pharmacy address:	

Insurance Carrier:	Insurance ID #:	Insurance Group #:
Insurance Subscriber's Name (Last, First, M.I.):		
Relationship to Patient:	Date of Birth:	Insurance Subscriber's Social Security Number:
Is the Insurance Subscriber's Employer INOVA Health System, Sentara, or MWH? *If yes please circle*		
Secondary Insurance Carrier:	Insurance ID #:	Insurance Group #:

Emergency Contact's Name:		Relationship to Patient:
Home Phone:	Cell Phone:	Work Phone:

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to Associates in Gastroenterology, a division of Advance Digestive Care, otherwise payable to me for services rendered, realizing I am responsible to pay non-covered services. I also realize that I am responsible for any other cost incurred while collecting my outstanding balance(s).

Authorization to Release Information: I hereby authorize Associates in Gastroenterology, a division of Advance Digestive Care, to release any information acquired in the course of my treatment necessary to process insurance claims.

No Show Policy: I understand that Associates in Gastroenterology, a division of Advance Digestive Care, may charge **a $50 fee** to me if I fail to present for a scheduled appointment. If I need to reschedule or cancel, I will coordinate with the office staff **at least 24 hours prior** to the scheduled appointment or I will be charged a $50 fee.

____

Signature Date

Waiver: I, ________________________________, agree to be seen by Associates in Gastroenterology, a division of Advance Digestive Care, on this date. I acknowledge that I did not bring a referral as required by my insurance company and/or I do not have my insurance card. I am electing to be seen today and agree to pay for services rendered without a valid referral or insurance card.

____

Signature Date

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COMMUNICATION AUTHORIZATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Associates in Gastroenterology, a division of Advance Digestive Care, will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work).

If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

I authorize the physicians and staff of Associates in Gastroenterology, a division of Advance Digestive Care, to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Associates in Gastroenterology, a division of Advance Digestive Care, if this authorization information changes.

It is okay to leave confidential medical information for me on my: (list numbers)

- ☐ Home telephone/answering machine ____________________________
- ☐ Work telephone ____________________________
- ☐ Mobile telephone ____________________________

It is okay to give confidential medical information to my: (list names)

- ☐ Spouse: ____
- ☐ Parent(s): ____
- ☐ Son/Daughter: ____
- ☐ Brother/Sister: ____
- ☐ Other: ____

I acknowledge that this authorization can only be amended or rescinded by my written authorization.

______________________________________ ____________________
Patient Name D.O.B.

______________________________________ ____________________
Patient Signature Date

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Notice of Privacy Practices Acknowledgement Form

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the material, please sign in the space provided below.

PATIENT RIGHTS YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding your PHI. You may:

1. Inspect and copy health data by submitting a written request to our Privacy Officer
2. Amend protected health information, if you believe it is incorrect, by submitting a written request to our Privacy Officer
3. Receive a list of disclosures made of your protected health data. To obtain this list of disclosures, you must submit your request in writing to our Privacy Officer. We may charge you for the costs of providing this list. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time before any costs are incurred
4. Request restrictions on certain uses and disclosures of facts about you. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you may have had. However, we are not required to agree to the requested restrictions. To request restrictions, you must submit a written request to our Privacy Officer
5. Receive confidential communication of protected health data by giving us a specific means of communication. For example, you can request that we only contact you at work or via U.S. mail. Please submit such a request in writing to our Privacy Officer
6. Obtain a paper copy of this notice upon request, if you agreed to originally accept this notice via e-mail or facsimile
7. You have the right to receive notice of breach of unsecured PHI. Unauthorized acquisition, access, use or disclosure of unsecured PHI is presumed to be a breach unless it is demonstrated that there is a low probability that the PHI has been compromised.
8. You have the right to restrict disclosure of psychotherapy notes and PHI if treatment is paid for out of pocket. You may request that PHI not be disclosed to a health plan if the item is typically disclosed for payment or health care operations (and not otherwise required by law) and the item/service has been paid in full by the individual or someone other than the health plan.

PROVIDER RIGHTS

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

____

Patient Name Date of Birth

____

Patient Signature Date

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Financial Policy

Welcome to Associates in Gastroenterology, a division of Advanced Digestive Care, LLC. This official financial policy advises you of your financial responsibility with respect to services received.

Patient Responsibility

1. It is your responsibility to present your current insurance card at every visit. If the information you provide is incorrect (either intentionally or unintentionally), you will be responsible for all charges.
2. According to the specifics of your insurance plan, you are responsible for payments due to your deductible, copayment, coinsurance, and payment for non-covered services. These amounts are due at the time of service.
3. It is your responsibility to provide a referral (either written or electronic) for all dates of service if a referral is required by your insurance.
4. Because our physicians' function as specialists or consultants (and not primary care physicians), we do not provide written or electronic referrals to other physicians that may be required by your insurance. For example, if our physicians refer you to see a surgeon, you may need to get a referral from your primary care provider if required by your insurance plan.

Types of Payment

1. Copayments: Insurance plans require that we collect your co-payment at the time of your visit.
2. Deductibles: Many insurance plans require you to pay a predetermined amount (the deductible) before insurance will cover any charges. If you have a plan with a deductible, we may collect a deposit to cover some or all of your deductible responsibility at the time of your visit.
3. Coinsurance: Many plans require you to pay a percentage (coinsurance) of allowable charges. If you have a plan requiring you to pay coinsurance, we may collect a deposit to cover some or all of your coinsurance responsibility at the time of your visit.

Fees

1. We accept cash, checks, Visa, Master Card, and Discover. There is a $50 charge for checks returned as non-payable.
2. If you are unable to keep your appointment, we require cancellation notice of one full business day for scheduled office visits and 7 full business days for scheduled procedures. Late cancellations, rescheduling, or missed visits will be charged $50 for office visits and $200 for procedure visits.
3. Any account turned over to the collection agency will be charged an extra 30% fee of the total due to cover our cost.

I have read and understand this financial policy and agree to accept the responsibility for any balance that becomes due for services.

Patient Print Name: ____ **D.O.B:**_______________

Patient (or Responsible Party) Signature: __________________________________ **Date:** ____________