GI SPECIALISTS OF GEORGIA

When you can't trust your gut, trust us.

www.gigeorgia.com
Main Line: 678.741.5000

Dear Patient,

Thank you for choosing GI Specialists of Georgia for your healthcare needs. We are looking forward to welcoming you to our practice.

Enclosed you will find patient information and medical history forms that will **need to be completed and brought to the office at the time of your appointment. Failure to complete these forms prior to your arrival at the facility may delay your appointment**. We also require a list of any medications you are taking, including dosage.

We accept and file most major insurances, including Medicare. Please bring your insurance card(s) with you so that we can create your record in our system and assist you with your insurance. If you have an outstanding balance or your insurance requires a deductible or co-payment, this will be collected at the time of your appointment.

GI Specialists of Georgia is comprised of multiple entities including clinical offices, endoscopy centers, histology and anesthesia services. In the event that one entity is overpaid for services rendered (this would include the practice and facility fees) and there is a balance owed on another, we reserve the right to transfer money between entities to cover open balances.

Again, thank you for choosing GI Specialists of Georgia for your healthcare needs. We will strive to make your relationship with us as pleasant as possible.

Physicians and Staff
GI Specialists of Georgia, PC

Enclosures

GI Specialists of Georgia and Associated Entities:
DCA Diagnostics ● GI Diagnostics Endoscopy ● Towne Lake Endoscopy
Anesthesia ● Histology Services

AUTHORIZATION RELEASE

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have had the opportunity to review a copy of GI Specialists of Georgia, PC "Notice of Privacy Practices".

X_____ Date:_____

Patient Signature

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION:

I hereby give GI Specialists of Georgia, PC permission to discuss any of my Medical Information with the following people:

Name: Relationship:

_____ _____

_____ _____

Is it permissible to leave Medical Information on an Answering Machine or Voicemail? YES NO

If yes, please list phone number(s) where we can leave messages:_____

I hereby authorize GI Specialists of GA, PC and all affiliated entities to obtain and share prescription medication history with my pharmacy.

X_____ Date:_____

Patient Signature

PERMISSION TO TREAT:

I voluntarily allow GI Specialists of Georgia, PC and all medical personnel to perform diagnostic studies, tests, x-ray examination, EKG, lab work, procedures or any other treatment or examination to me during the period of medical or surgical care, they consider pertinent.

X_____ Date:_____

Patient Signature

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS:

I hereby authorize direct payment to the doctor whose name appears for surgical or medical benefits. I understand I am financially responsible for non-covered services, co-payments and any portion of deductible not paid by the insurance company.

I hereby authorize GI Specialists of Georgia, PC to release any information required to my health insurance provider for the purpose of processing claims for services I received from GI Specialists of Georgia, PC.

CANCELLATION / NO SHOW POLICIES:

Our office requires 2 business days' notice for cancellations or reschedules of Office Appointments. Failure to cancel without 2 days' notice may result in a fee of $20.00.

Our office requires 5 business days' notice for cancellations or reschedules of Procedures. Failure to cancel without 5 days' notice may result in a fee of $50.00. Patients that fail to show for a procedure are subject to a $200 fee.

Patients with a history of multiple cancelled or rescheduled procedures may result in a $200 deposit being required prior to scheduling.

PAYMENT:

Co-payments and deductibles are due prior to services being performed unless other arrangements have been made with Patient Financial Services. We will file with your insurance as a courtesy; payment is the patient's responsibility. Any unpaid balance is due within 30 days of services rendered. Failure to pay could result in account being placed with an outside collection agency.

GI Specialists of Georgia (GSG) is comprised of multiple entities. In the event that one entity is overpaid for services rendered (includes the practice, facility fees, anesthesia and histology services) and there is a balance owed on another GSG entity, we reserve the right to transfer money between entities to cover open balances.

FEE FOR COPIES OF MEDICAL RECORDS:

In accordance with Georgia Legislative Code 31-33-3(a) there will be an administration charge for copies of all medical records.

By my signature below, I acknowledge I have read this form and I fully understand the policies and procedures.

Patient Signature:_____ Date:_____

GASTROINTESTINAL SPECIALISTS OF GEORGIA, PC

Patient History Form

Patient Name:_____ DOB:_____ Date:_____

Primary Care Physician:_____ Referred By:_____

Race/Ethnicity (Medicare Required):_____ Height:_____ Weight:_____

MEDICATIONS: Are you on any of these medications?

O Aspirin O Plavix/other blood thinners O Arthritis Medications

O Ibuprofen Products O Coumadin/Warfarin O Insulin

Please list all your medications and dosages (or provide a separate list if you prefer):

_____

ALLERGIES: O None O Latex O Iodine O Others (please list):_____

CURRENT SYMPTOMS/ILLNESSES: _____

MEDICAL HISTORY: Please fill in circles completely and write in additional comments

	Year & Comment		*Year & Comment*
O History of colon cancer	_____	O Hypertension	_____
O History of colon polyps	_____	O Heart attack or Heart disease	_____
O Reflux disease	_____	O Stroke	_____
O Barrett's esophagus	_____	O High cholesterol	_____
O Crohn's disease	_____	O Lung disease	_____
O Ulcerative Colitis	_____	O Diabetes	_____
O Anemia	_____	O Cancer history	_____
O Hepatitis	_____	O Psychiatric disorder	_____
O Other Liver disease	_____	O Arthritis	_____
O Irritable Bowel Syndrome	_____	O Thyroid disease	_____

Please list any other pertinent medical problems:_____

CONTINUED ON BACK

PAST SURGICAL HISTORY: Please fill in circles completely and write in additional comments

	Year & Comment		*Year & Comment*
O Gallbladder surgery	_____	O Coronary stent / Bypass surgery	_____
O Stomach surgery	_____	O Heart valve surgery	_____
O Colon surgery	_____	O Pacemaker / Defibrillator	_____
O Other abdominal surgery	_____	O Thyroid surgery	_____
O Hemorrhoidectomy	_____	O Hernia repair	_____

Other Surgeries:_____

SOCIAL HISTORY: Please fill in circles completely and write in additional comments

Alcohol use:	Tobacco use:	Illicit Drug use:	Have you ever had:
O None	O None	O Never	O Tattoo
O <1 Drink/day	O Less than ½ pack/day	O Past Experimentation	O Blood Transfusion
O 1-2 Drinks/day	O 1 pack/day	O Former Use	
O 3 or more drinks/day	O More than 1 pack/day	O Recent/Active Use	
O Former alcohol use	O Former tobacco use	Type of Drug: _____	

FAMILY HISTORY: Please fill in circles completely and write in additional comments

	Father	Mother	Sibling	Child	Grandparent	Other	Age at Diagnosis
Colon Cancer	O	O	O	O	O	O	_____
Colon Polyps	O	O	O	O	O	O	_____
Ulcerative Colitis	O	O	O	O	O	O	_____
Crohn's Disease	O	O	O	O	O	O	_____
Celiac Disease	O	O	O	O	O	O	_____
Liver Disease	O	O	O	O	O	O	_____
Gallbladder Disease	O	O	O	O	O	O	_____
Pancreatic Cancer	O	O	O	O	O	O	_____

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____

Anesthesia Signature:_____ Date:_____

Staff Signature:_____ Date:_____

GI SPECIALISTS OF GEORGIA

Consent to Receive Test Results via Patient Portal

GI Specialists of Georgia's preferred method of delivery on non-urgent test results and communication with you is via our Patient Portal.

Any patient who has internet access can obtain a summary of their medical information, is able to communicate with their physician for non-urgent or emergent matters, request appointments, request prescription refills and receive appointment reminders.

Please indicate your desire to utilize this very useful communication tool:

○ Yes, I wish to receive non-urgent test results and non-urgent communications via my secure patient portal access.

_____
Current Email

○ No, I do not wish to use the patient portal at this time.

_____ _____
Patient or Legal Representative Date

2021-09-21