GI SPECIALISTS OF GEORGIA

www.gigeorgia.com

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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.

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

Enclosures

Gastrointestinal Specialists of Georgia, PC

PATIENT INFORMATION SHEET

FIRST NAME_____ MI_____ LAST NAME_____

ADDRESS_____ EMAIL_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____

CELL PHONE_____ DATE OF BIRTH (mm/dd/yyyy)_____

SOCIAL SECURITY #_____ SEX: M____ F____ RACE _____

ETHNICITY_____ MARITAL STATUS: S_____ M_____ D_____ W_____

EMPLOYER NAME_____ OCCUPATION_____

EMPLOYER ADDRESS_____

(1) PRIMARY INSURANCE_____

ID#_____ GROUP NAME/NUMBER _____

POLICY HOLDER'S FULL NAME _____

POLICY HOLDER'S RELATIONSHIP TO THE PATIENT _____

POLICY HOLDER'S DOB (m/dd/yyyy)_____POLICY HOLDER'S SSN _____

(2) SECONDARY INSURANCE_____

ID#_____ GROUP NAME/NUMBER_____

POLICY HOLDER'S FULL NAME_____

POLICY HOLDER'S RELATIONSHIP TO THE PATIENT_____

POLICY HOLDER'S DOB (m/dd/yyyy)_____POLICY HOLDER'S SSN _____

Who referred you: _____

Who is your Primary Care Physician: _____

Pharmacy Name_____ Pharmacy Phone_____

Nearest relative not living with you in case of emergency_____

Relation_____ TEL #_____

If you are unable to keep your appointment, please call our office. Failure to do so will result in a $20 charge being billed to you.

GASTROINTESTINAL SPECIALISTS OF GEORGIA, INC.

Patient Follow-Up History Form

Patient Name:_____ Age: _____ DOB:_____ Date: _____

Primary Care Physician: _____ Consult Requested By: _____

Current Symptoms/Illnesses: _____

Allergies: O None O Latex O Iodine O Others (Please List) _____

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

Social History:

Are you a smoker? O Yes O No

Alcohol Use? O Yes O No

REVIEW OF SYSTEMS: (Fill in ALL of the following you have experienced over the last year OR fill in "None")

CONST:	O None	O Fever	O Fatigue		
ENMT:	O None	O Bad breath	O Difficulty swallowing	O Jaundice	O Bleeding gums
		O Oral ulcers	O Sinus postnasal drip	O Nosebleeds	O Hoarseness
DERM:	O None	O Skin rash	O Skin sores		
RESP:	O None	O Cough	O Shortness of breath	O Asthma/Wheezing	O Cough up blood
CARDIAC:	O None	O Chest pain	O Irregular heart beat	O Rapid Heart Rate	O Palpitations
MUSC:	O None	O Leg cramps	O Muscle/Joint Pains	O Low back pain	
NEURO:	O None	O Seizures	O Numbness/weakness	O Fainting/dizziness	O Headaches
HEME:	O None	O Bruise easily	O Genetic bleeding disorder	O Blood clots history	O Excess bleeding
ENDO:	O None	O Weight loss	O Heat/cold intolerance	O Excessive thirst	O Excess urination
PSYCH:	O None	O Panic attacks	O Anxiety all the time	O Inability to think	O Inability to sleep

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:

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

_____
Current Email

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

_____ _____
Patient or Legal Representative Date

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:_____

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.

*X*_____ Date:_____

Patient Signature

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

CANCELLATION POLICIES:

Our office requires 48 business hours' notice for cancellations or reschedules of office appointments or procedures. Failure to cancel or reschedule an appointment or procedure without 48 hours' notice will result in a fee of $50.00 for procedures and $20.00 for office appointments. Failure to show up for a scheduled procedure will result in a $200.00 fee.

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:_____