GASTROENTEROLOGY ASSOCIATES OF CENTRAL GA, LLC

Raymond Bedgood, D.O. — Harold Harrison, M.D.
Davey R. Deal, Jr, M.D. — Adam Levy, M.D.
Carley Ebanks, M.D. — Shahriar Sedghi, M.D.

PATIENT DATA FORM MUST BE COMPLETED IN FULL **Today's Date** _____

Name _____ **Date of Birth** _____

Mailing Address _____

Street City State Zip

Phone Numbers Home _____ Cell_____ Work_____

Primary Phone is ❑ **Home** ❑ **Cell** ❑ **Work** **Can we text you?** ❑ Yes ❑ No

Primary Care Physician: _____ **Referring Physician:** _____

Gender ❑ Male ❑ Female **Marital Status** ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Social Security # _____

Employer _____ **Dept. | Title** _____

Employer's Address _____

Street City State/Zip

Email Address _____

Race _____ **Ethnicity** _____ **Language** _____

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you

_____

Name/ Relationship Phone Date of Birth

Nearest relative or friend not living with you

_____

Name/ Relationship Phone Date of Birth

INSURANCE INFORMATION (We do need you to write your insurance information even if we have a copy of your cards)

PRIMARY Company _____Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

SECONDARY Company _____Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address_____

Street City State/Zip

I authorize Gastroenterology Associates, LLC to obtain my prescription history electronically. ❑ Yes ❑ No

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of GAOCG, LLC and its affiliates this includes services provided by a Physician Assistant or Nurse Practitioner under the supervision of a GAOCG physician. I understand that I may ask for any medications prescribed by the Physician Assistant or Nurse Practitioner to be reviewed by a physician prior to having the prescription filled. I authorize payment of medical benefits to GAOCG, LLC and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient / Guarantor Signature* _____ Date _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

Patient Name _____ Date of Birth _____

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ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that GAOCG, LLC, has given me the opportunity to read a detailed notice of their Privacy Practices. A Copy of Privacy Practices are posted in the lobby and a copy can be requested at the front desk.

_____ _____
Patient/Authorized Representative Signature Date

If not signed, please provide a reason why the acknowledgement was not obtained.

_____ _____
Witness / Staff Signature Date

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from GAOCG, LLC, to share information regarding care or tests results with the individuals listed below. These individuals may also request protected health information on my behalf.

_____

Name Phone Relationship/Date of Birth

_____

Name Phone Relationship/Date of Birth

_____

Name Phone Relationship/Date of Birth

Is it OK to leave results or information on your voicemail? ❑ Yes ❑ No

_____ _____
Patient/Authorized Representative Signature Date

CONSENT TO CORRESPOND ELECTRONICALLY

While GAOCG, LLC, takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication. I acknowledge that if I use electronic mail to initiate contact with a GAOCG provider regarding medical care, the GAOCG physician and/or his/her representative has my permission to correspond via that email address. I give permission for a GAOCG physician or clinical staff member to email me at @ _____ regarding medical care.

_____ _____
Patient/Authorized Representative Signature Date

Financial Disclosure Statement

Thank you for choosing GAOCG, LLC. Please read and sign this **Financial Disclosure Statement** prior to your appointment. Patients who do not pay in full at the time of service, must complete the required information and insurance forms before services will be rendered.

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- You can expect to receive the following bills: **Physician Fee**: Fee paid to the physician for performing the service. This bill will be from GAOCG, LLC. **Lab Fee:** If a lab test is ordered, a separate bill will come from a lab or a radiologist. **Endoscopy Fee:** If a procedure is performed at the Endoscopy Center of Middle Georgia, LLC, a separate bill will come from the Endoscopy Center of Middle Georgia, LLC.
- Some insurance companies require pre-certification for this service. We will make every effort to verify your benefits and obtain any necessary pre-cert prior to your appointment. This is not a guarantee of payment.
- Your insurance company will send you an **Explanation of Benefits** that will explain how your bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand your insurance benefits.
- Some insurance plans require you to pay different **out-of-pocket** amounts based on the location where the service is performed. **Deductibles**, **co-insurance** and **co-payments** may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as, any non-covered services outlined in your health plan. We will submit primary, secondary, and tertiary claims on your behalf when the information needed to process the claim is obtained and verified before your visit. **If this information is obtained after your visit or if the information provided is deemed inactive for the dates of service, the patient or guarantor is responsible for the balance.**
- We accept cash, checks, and major credit cards. GAOCG, LLC, collects **co-payments** at the time of service. Additional payment may be required based on your insurance plan. For additional questions regarding billing or payment arrangements, call the office and ask to speak to the financial counselor, Karen Minter at ext. 107. **A $30.00 fee will be incurred for returned checks.**
- **Cancellation Fee:** If you are unable to keep your appointment, please reschedule at least 24 hours in advance. A missed appointment will result in a $25.00 fee. A $50.00 fee will be incurred after (3) missed appointments. Multiple, consecutive missed appointments will result in a discharge from the practice due to noncompliance. **If you must cancel or reschedule your procedure, please call as early as possible**. We require at least 48 hour notice of any change to your scheduled procedure or you could be subject to a $100.00 missed procedure fee. Multiple missed procedure appointments will result in being discharged from the practice due to non-compliance.
- **Medicare Authorization:** I request that payment of authorized Medicare benefits be made on behalf of GAOCG, LLC for any of the services furnished. I authorize any holder of medical information about me to release to the Healthcare Financing Admin and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. GAOCG, LLC agrees to accept the charge determination of the Medicare carrier as the full charge. The Patient is only responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are decided by the Medicare carrier

Patient's Reassignment and Release Statement By signing below, I understand the billing practices of GAOCG, LLC. I may receive multiple bills related to my service as explained above. I authorize payment of medical benefits to GAOCG, LLC and authorize them to release any medical information necessary to process claims. I give GAOCG, LLC permission to apply payments received to balances due at GAOCG, LLC. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan

_____ _____

Patient/Authorized Representative Signature — Date

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CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

_____	_____	_____
Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient): _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.

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Name _____ Age_____ Date of Birth _____

Referred by _____ Primary Care Physician_____

Other physicians involved in your healthcare _____

_____

Describe the reason(s) for your visit _____

_____

_____

1) Have you been out of the country in the last 6 months? ❑ **Yes** ❑ **No**

2) PATIENT MEDICAL HISTORY **Check all that apply**

- ❑ Cirrhosis
- ❑ Colon Cancer
- ❑ Colon Polyps
- ❑ Crohn's Disease
- ❑ Diverticulitis
- ❑ Diverticulosis
- ❑ End Stage Renal Disease (ESRD)
- ❑ GERD
- ❑ Hepatitis B
- ❑ Hepatitis C (HCV)
- ❑ Hiatal Hernia
- ❑ Cancer: Type _____
- ❑ Other _____
- ❑ Irritable Bowel Syndrome
- ❑ Liver Disease
- ❑ Stomach/Intestinal Ulcers
- ❑ Ulcerative Colitis
- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Other mental illness
- ❑ Arthritis/Osteoarthritis
- ❑ Asthma
- ❑ Cataracts
- ❑ Hypertension
- ❑ Congestive Heart Disease (CHF)
- ❑ COPD/Emphysema
- ❑ Coronary Artery Disease (CAD)
- ❑ Diabetes
- ❑ Glaucoma
- ❑ HIV/AIDS
- ❑ Hyperlipidemia/High Cholesterol (HLD)
- ❑ Chronic Kidney Disease (CKD)
- ❑ Hypothyroidism
- ❑ Migraines
- ❑ Myocardial Infarction/ Heart Attack
- ❑ Nerve/Muscle Disease
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pancreatitis
- ❑ Seizures
- ❑ Stroke (CVA)
- ❑ Sleep Apnea

3) VACCINES

Have you ever had any of the following vaccines? ❑ Influenza (Flu) ❑ Hepatitis A ❑ Hepatitis B ❑ Pneumococcal vaccine ❑ Other _____

4) SURGICAL HISTORY **Check all that apply and provide dates**

- ❑ Colon Surgery _____
- ❑ Colonoscopy _____
- ❑ Hemorrhoid Surgery _____
- ❑ Gallbladder Surgery _____
- ❑ Gastric Surgery _____
- ❑ Heller Myotomy _____
- ❑ Liver Surgery _____
- ❑ Reflux Surgery _____
- ❑ Small Intestine Surgery _____
- ❑ Upper Endoscopy (EGD) _____
- ❑ Laparotomy _____
- ❑ Appendectomy _____
- ❑ Brain Surgery _____
- ❑ Breast Surgery _____
- ❑ C-Section _____
- ❑ CABG/Heart Surgery _____
- ❑ Defibrillator _____
- ❑ Hernia Surgery _____
- ❑ Hysterectomy _____
- ❑ Joint Replacement _____
- ❑ Obesity Surgery _____
- ❑ Pacemaker _____
- ❑ Prostate Surgery _____
- ❑ Spinal Surgery _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Transplant Surgery _____
- ❑ Tubal Ligation _____
- ❑ Valve Replacement _____
- ❑ Vasectomy _____
- ❑ Other _____

Name _____ Date of Birth _____

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5) MEDICATIONS (if you have a list please bring to front desk)
List Current Medications (including herbal) and Dosage

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you currently taking any of the following blood thinners? ❑ Coumadin ❑ Plavix ❑ Warfarin
❑Xarelto ❑Other _____

Are you currently taking any of the following aspirin/NSAIDs? ❑ Advil ❑ Aleve ❑ BC Powder
❑ Goody's Powder ❑ Ibuprofen ❑ Naprosyn
❑Other _____

6) ALLERGIES
List any medication or food allergies ❑ No known medication/food allergies

_____
_____

7) FAMILY HISTORY (1st degree relatives) Check all that apply

	Mother	Father	Sister	Brother	Son	Daughter	Age at Diagnosis
Barrett's Esophagus	❑	❑	❑	❑	❑	❑	_____
Colon Polyps	❑	❑	❑	❑	❑	❑	_____
Crohn's Disease	❑	❑	❑	❑	❑	❑	_____
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	_____
Liver Disease	❑	❑	❑	❑	❑	❑	_____
Hyperlipidemia/ High Cholesterol (HLD)	❑	❑	❑	❑	❑	❑	_____
Diabetes	❑	❑	❑	❑	❑	❑	_____
Heart Disease/ Coronary Artery Disease	❑	❑	❑	❑	❑	❑	_____
Cancers							
○ Colon	❑	❑	❑	❑	❑	❑	_____
○ Esophagus	❑	❑	❑	❑	❑	❑	_____
○ Stomach	❑	❑	❑	❑	❑	❑	_____
○ Other (Specify)	❑	❑	❑	❑	❑	❑	_____
None of the Above	❑	❑	❑	❑	❑	❑	

Name _____ Date of Birth _____

8) SOCIAL HISTORY

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Provide details regarding current and/or past used of the following:

Alcohol (beer, wine, liquor) ❑ Yes ❑ No Usage_____

I.V. or Recreational Drugs ❑ Yes ❑ No Usage _____

Tobacco (cigarettes, cigars, chewing tobacco) ❑ Yes ❑ No Usage _____

Smoking Status: ❑ Every Day ❑ Some Days ❑ Former ❑ Never

Tattoos: ❑ Yes ❑ No

Piercings: ❑ Yes ❑ No

Patient Signature _____ Date_____