Gastrointestinal Associates, LLC.

Patient Registration Form

☐ Return this paperwork immediately
Mail: 10116 W. 105th St. Fax: 913-307-2010
Overland Park, KS 66212

☐ Bring these forms with you to your appointment
Appointment Date: _____
☐ Office Visit ☐ Procedure

☐ Jeff L. Young, M.D.
☐ J. Chris Nichols, M.D.
☐ Christian C. McElhinney, M.D.
☐ James E. Allen, MD
☐ Donald J. Martin, M.D.
☐ S. Robert Holmes, D.O.
☐ R. Andrew Sutton, D.O.
☐ Matthew P. Harrison, M.D.
☐ Matthew B. Moore, M.D.
☐ Soumojit Ghosh, M.D.
☐ Kelci Gillenwater, APRN
☐ Jessica Taylor, PA
☐ Kathleen Johnson, APRN

Please PRINT & complete ALL selections:

Patient Name: _____ Date of Birth: _____

SSN: _____ Sex: Male/Female Marital Status: _____

Address: _____Apt_____ City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

Email: _____

Race: ☐White ☐Black/African-American ☐Amer. Indian/Alaskan Native ☐ Asian ☐Hawaiian/Other Pacific Island ☐Other Race

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Decline to Specify ☐Unknown Language:_____

Employer Name: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Primary Care Physician:	Phone Number: Fax Number:

Primary Insurance:	Member ID:	Group #:
Policy Holder's Name:	***Relationship:***	***DOB:***
Claims Mailing Address:		

Secondary Insurance:	Member ID:	Group #:
Policy Holder's Name:	***Relationship:***	***DOB:***
Claims Mailing Address:		

CONTINUE ON BACK SIDE →

Patient Name: _____

Date of Birth: _____

COMMUNICATION AUTHORIZATION

METHOD OF DISCLOSURE:

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of the protected health information. Please indicate how you wish to be contacted for scheduling, treatment, test results, financial or other information regarding your care (check all that apply):

☐ Home phone:	☐ Detailed message	☐ General message with call back # only
☐ Cell phone:	☐ Detailed message	☐ General message with call back # only
☐ Work phone:	☐ Detailed message	☐ General message with call back # only

Our office may use text messaging to communicate. If you wish to **opt out** please initial here _____

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby allow Gastrointestinal Associates, LLC, to discuss scheduling, treatment, test results, financial or other information regarding my care with the following individuals. This consent will be considered valid until such time that I revoke it. It will be my responsibility to keep this information up to date, as I recognize that relationships may change.

Name:	Relationship:	Contact #:

Authorization of Treatment: While I am here I permit the employees, healthcare provider, and all other persons caring for me to treat me in ways they judge beneficial to me. I understand the attending healthcare provider will explain to me the nature of my condition and his/her recommended treatment and associated risk involved. I further understand that this care may include diagnostic testing, examinations, medical and/or surgical treatment and no guarantees have been made to me about the outcome of this care.

Medicare / Medicaid Lifetime Consent: I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct. I authorize any holder of medical and/or other information about me to release it to the Social Security Administration or its intermediaries or carriers as needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits to the healthcare provider or organization to submit a claim to Medicare for payment to them.

All Other Insurance: Authorization is hereby granted to Gastrointestinal Associates, LLC and any associated healthcare entities to release medical records and required information as requested for completion of my claims to my insurance company. I further authorize payment for medical benefits to be made directly to Gastrointestinal Associates, LLC.

I understand that I am personally responsible for all services provided by Gastrointestinal Associates, LLC and any associated healthcare entities. I understand my disclosure of health information and any changes must be made in writing. By signing below I agree and acknowledge the following terms and that all information provided is accurate.

_____	_____	_____
Patient Signature	**Patient Representative Signature/Relation**	**Date**

Gastrointestinal Associates, LLC
Diplomats of the American Board of Internal Medicine and Gastroenterology

Patient Name: _____

Date of Birth: _____

Date: _____

History of Present Illness

Initial Symptoms: _____

Date of Onset: _____

Progression of Symptoms: _____

_____

_____

_____

What initiates symptoms: _____

What relieves symptoms: _____

Associated symptoms: _____

Character of symptoms recently: ☐ More Frequent ☐ More Intense ☐ Continuous
☐ Less Frequent ☐ Less Intense ☐ Periodic

Review of Systems

Check those which have occurred recently:

Gastrointestinal
___Abdominal pain
___Nausea
___Vomiting
___Bloating
___Belching
___Heartburn
___Irregular bowel habits
___Constipation
___Diarrhea
___Gas
___Hemorrhoids
___Hernia
___Poor appetite
___Food intolerances
___Blood in stool
___Black stools

General
___Weight gain
___Weight loss
___Fatigue
___Fever

Musculoskeletal
___Joint pain/swelling
___Back pain

Skin
___Rashes
___Itching
___Sores

Throat
___Soreness
___Hoarseness
___Trouble swallowing

Blood
___Anemia
___Low blood iron

Psychiatric
___Anxiety
___Depression
___Irritability
___Hallucinations
___Drug dependency

Medications & Allergies

Patient Name: _____

Date of Birth: _____

**** PLEASE TYPE OR PRINT CLEARLY ****

List ALL Prescription, Over-the-counter and Supplements

NAME	DOSAGE	FREQUENCY
EXAMPLE: Aspirin	81mg	1 time/day

Pharmacy:_____**Location:**_____

Phone:_____ **Fax:**_____

☐ **No Known Drug Allergies**

ALLERGIES:	REACTION:

Past Medical History

Patient Name: _____

Date of Birth: _____

Previous Illnesses: (Check all that apply)

ANEMIA
____ Iron Deficiency
____ Vitamin B12 Deficiency

BLOOD DISEASE
____ Leukemia
____ Bleeding Disorder
____ Blood Clots
____ Clotting Problems

CARDIOVASCULAR
____ Heart Attack
____ Heart Stents
____ Hypertension
____ High Cholesterol
____ High Triglycerides
____ Angina/Chest Pain
____ Atrial Fibrillation
____ Coronary Artery Disease
____ Pacemaker
____ Implanted Cardioverter

ENDOCRINE
____ Diabetes Type I
____ Diabetes Type II
____ Hyperthyroid
____ Hypothyroid

ENT
____ Seasonal Allergies
____ Sleep Apnea

GASTROINTESTINAL
____ Duodenal Ulcer
____ Gastric Ulcer
____ Duodenitis
____ Hiatal Hernia
____ Gallstones
____ Pancreatitis
____ Colon Polyp
____ Diverticulosis
____ Diverticulitis
____ Ulcerative Colitis
____ Crohn's Disease
____ Hemorrhoids
____ Anal Fissure
____ Fistula
____ Irritable Bowel Syndrome
____ Bowel Obstruction
____ GERD (reflux)
____ Barrett's Esophagus
____ Gastroparesis
____ Lymphocytic Colitis
____ Collagenous Colitis
____ C. diff
____ Eosinophilic Esophagitis

NEUROLOGY
____ Multiple Sclerosis
____ Stroke/CVA
____ TIA

PSYCHOLOGICAL
____ Depression
____ Mental Illness
____ Anxiety

PULMONARY
____ Emphysema
____ Bronchitis
____ Pneumonia
____ Asthma
____ TB
____ COPD

VACCINES
____ Hepatitis A
____ Hepatitis B
____ Pneumonia

MISC
____ Gout
____ Arthritis
____ Skin Problems
____ Fibromyalgia
____ Hernia-Type_____
____ Osteoporosis
____ Vitamin D Deficiency

CANCER
Type
_____

LIVER
____ Jaundice
____ Hepatitis
____ A
____ B
____ C
____ Cirrhosis
____ Ascites

OTHER:
_____
_____
_____

Date of last Colonoscopy: _____ **Provider/Location:** _____

Previous Surgery

Date	Surgery	Physician/Hospital

Family History

Patient Name: _____

Date of Birth: _____

Family History Unknown/Patient Adopted ☐
Please mark all that apply

Diagnosis	Living (circle one)	Colon Cancer	Colon Polyps	Ulcerative Colitis	Crohns Disease	Ulcer	Gallbladder Disease	Hepatitis	Liver Disease/Cancer	Stomach Cancer	Pancreatic Disease/Cancer	Breast Cancer	Uterine Cancer	Celiac Disease	Other	
Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Brother(s)	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
Sister(s)	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Children	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
PG-Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
PG-Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
MG-Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
MG-Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Social History

Occupation: _____

Alcohol Use:
☐None ☐Beer (____ bottles per week) ☐Wine (____ glasses per week) ☐Hard Liquor (____ drinks per week)

Caffeine Use:
☐None ☐1-2 per day ☐3-4 per day ☐more than 5 per day

Tobacco Use:
☐Never a smoker ☐Current Every Day Smoker (_____ packs per day, _____ # of years)
☐Current Some Day Smoker ☐Former Smoker (quit date _____)
Chewing Nicotine Containing Substance (Chewing tobacco) ☐Current ☐Former

Recreational Drug Use:
☐Never ☐Currently Using IV drugs ☐Used IV drugs in the past ☐ Currently using marijuana

Gastrointestinal Associates, LLC
Patient Financial Responsibility Form

The physicians at our office are contracted with a variety of insurance plans. We also provide services for private pay patients. We will submit claims to your primary insurance carrier and one secondary insurance carrier (if applicable). Our office does not contract or file claims with **health share plans or auto and liability insurances**. Payment is required at time of service and we will provide you with an itemized statement to file for reimbursement from the insurance company. Our physicians do not contract with any Medicaid plans or Medicare Advantage D-SNP plans.

Please remember it is your responsibility to know and understand the coverage, benefits and requirements of your health insurance plan. It is your responsibility to verify, with your insurance company, that you are scheduled with an in-network provider. Our office cannot guarantee that information for you as there are thousands of plans and many different provider networks with each insurance company. Benefits will be determined by your insurance company, after they receive our claim. If you would like us to submit a claim for your services, you must provide the correct insurance information when speaking to registration or when you come in for your office visit. Office visit **copays** are due at the time of service. We accept cash, check, and major credit cards. If you are not prepared to pay your copay or private pay balance at the time of service, it may be necessary to reschedule your appointment.

If you have an out-patient procedure you may receive charges from the physician, facility, anesthesiologist or pathologist. Our office only has information related to the physicians' charges and, in some instances, the pathologists' charges. We can provide you with the phone numbers to contact the other offices for information regarding their charges. Our business office will verify that your insurance policy is active, **for the physician only**, on scheduled procedures. If you need more detailed policy information, you will need to contact your insurance company. Our office is compliant with the No Surprises Act. For more information, please see our website **kc-gi.com**. Look for the document titled **"Your Rights and Protections Against Surprise Medical Bills"**.

Screening colonoscopies are considered a preventative service and covered by most insurance companies at 100%. However, there are strict guidelines, set by your insurance policy, regarding what is considered a screening colonoscopy. This includes factors such as personal and family medical history, active symptoms or other colon cancer risk factors. You can find more information and FAQ's regarding screening, surveillance and diagnostic colonoscopy on our website, **kc-gi.com**. Look for the section titled **"What You Need to Know about Colonoscopy and Insurance Benefits"**. Our office does not offer long-term financing of balances for services we provide. Limited payment plans may be available but must be approved by our Business Office Manager. In the event your balance is not paid timely and we must employ a collection agency or attorney, all interest and/or fees for collection will be the responsibility of the patient in addition to the balance for healthcare services received.

Credit Card/Debit Card Authorization Policy

Our policy is that a credit card, debit card or HSA card information be securely stored for payment of patient balances after insurance or for private pay. There are a few insurance plans excluded from this policy. Our Registration Department will inform you if your plan meets these exclusions. If you do not wish to leave a credit card on file, we will collect, in advance, an **estimated** patient responsibility based on our contracted rate with your insurance company. This will be an **ESTIMATE** only and there may be additional charges as exact amounts cannot be determined prior to your procedure. A credit or debit card on file will be charged only if your account has a balance more than 30 days past due. If you do not provide a credit or debit card or pay an estimated patient responsibility, prior to being seen by our providers, it may be necessary to reschedule your appointment. After your insurance company processes your claim, Gastrointestinal Assoc., LLC will send a statement either to the mailing address or email address on file, providing you with any balance due that is your responsibility. If you have questions about your bill, you must contact the business office at **913-541-0510**.

By my signature below, I authorize Gastrointestinal Associates, LLC to securely store my credit card information and only charge it should I have an outstanding balance or any balance from a processed claim in the future. I am aware that the storage system used is fully compliant to the highest level of credit card storage security and regulations. Once stored, I am aware that only the last 4 digits of my card are viewable by Gastrointestinal Associates, LLC personnel. I understand that I am responsible for all charges for services that I receive from Gastrointestinal Associates, LLC and that if the patient responsibility portion of my charges (including charges applied to my deductible and/or coinsurance) is not paid in full within 30 days following receipt of the patient statement, Gastrointestinal Associates, LLC will charge my stored credit card for the outstanding balance due. I understand should I make a claim of fraud to charges on my credit/debit card, as described in this policy, I will be responsible for payment of the balance for services received and all fees associated with the dispute.

I have read, understand and agree to all provisions of the Patient Financial Responsibility Form:

Patient name (printed)	**Date of Birth**
Signature	**Date**