Alabama Colon & Gastro, P.C.

Basic Patient Information

Patient's Social Security Number:_____ Date:_____

Name of Patient:_____
First Middle Last

Date of Birth:_____ Age:_____ Gender: ___F ___M

Mailing Address:_____ City:_____ State:_____ Zip:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____

Email:_____ Employer:_____

Billing Information/Responsible Party/Guarantor for Encounter

Responsible Party: _____
(If Different from Patient) First Middle Last

Mailing Address:_____ City:_____ State_____ Zip_____

Street Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Responsible Party's SSN:_____ Gender __F __M

Home Phone: ( )_____ Cell Phone: ( )_____ Work Phone: ( )_____

Responsible Party's Email:_____ Employer:_____

Insurance Coverage - Primary

Please present your insurance card & driver's license to the front desk receptionist when returning this form.

Name of Insurance:_____

Policy Number:_____ Effective Date:_____

Group Number:_____ Co-Pay Amount:_____

Patient's Relationship to Policyholder: ____Self ___Child ___Spouse ___Guardian __Other

Name of Policyholder:_____ Gender: ___Female __Male
(If different from above) First Middle Last

Date of Birth:_____ Phone: ( )_____

Name of Policyholder's Employer:_____

(PLEASE SEE OTHER SIDE)

Alabama Colon & Gastro P.C.

Insurance Coverage - Secondary

Name of Insurance:_____

Policy Number:_____ Effective Date:_____

Group Number:_____ Co-Pay Amount:_____

Patient's Relationship to Policyholder: ____Self ___Child ___Spouse ___Guardian __Other

Name of Policyholder:_____ Gender: ___Female __Male
(If different from above) First Middle Last

Date of Birth:_____ Phone: ( )_____

Name of Policyholder's Employer:_____

Additional Patient Information

Race: ____American Indian/Alaska Native _____Asian _____Native Hawaiian/Pacific Islander

____Black or African American _____White _____Other_____

____Unknown _____Refused to Report

Ethnicity: _____Hispanic or Latino _____Non-Hispanic or Latino ____Unreported/Refuse to Report

Primary Language: _____Arabic _____Chinese ____English ____French ____German ____Spanish

_____Other:_____

Marital Status: ___Single ___Married ___Divorced ___Widow

Spouse Name:_____Phone:_____

How did you Hear About Us?

Were you referred to our practice? ___Yes ____No

If no, how did you hear about the practice?

- ACG Facebook Page
- Family Member
- Friend
- Internet
- Printed Advertisement
- Yellow Pages
- Other:_____

Referring Physician:_____

Primary Care Physician:_____

Policies and Procedures

Please initial each section below to indicate you have read and understand the information:

_____Assignment of Insurance and Financial Responsibility

I do, hereby, authorize payment of all insurance benefits, basic and major medical, for the services I receive, to be made directly to Alabama Colon & Gastro, P.C. I understand that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing or attempting to collect or secure payment, including reasonable attorney or collection agency fees.

_____Statement to Permit of Medicare Benefits to Provider and Patient

I request that payment of authorized Medicare or other applicable private insurance benefits be paid directly to Alabama Colon & Gastro, P.C. for services provided under their care. I also authorize Alabama Colon & Gastro, P.C. to release necessary medical information to my insurance company, its agents or any third party in order to determine payable benefits for services rendered.

_____Consent for Medical Services

I authorize Alabama Colon & Gastro, P.C. to render treatment to me/my dependents for services as may be deemed necessary.

_____Referrals/Authorizations

I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full will be required at the time of service.

_____Privacy Policy Notice

A copy of Alabama Colon & Gastro, P.C.'s Notice of Privacy Policies may be requested detailing how my information may be used and disclosed as permitted under federal and state law.

_____Missed Office Appointments

Our office requires a 24-hour notice for cancellations. Failure to do so may results in a $25 fee for medical appointments. This cancellation fee is not covered by your insurance.

_____Missed Procedure Appointments

In order to provide our patients with the highest level of care, any procedure cancellation with less than 48 hour notice may result in a $75 cancellation fee. This cancellation fee is not covered by your insurance and payment of this fee will be required prior to rescheduling the missed procedure.

_____Other Financial Fees

We charge a fee of $20, which must be paid in advance, for each disability, medical leave, financial statement, or FMLA form that we are asked to complete. There will be a $10 administration service charge for filling out any Prior Authorization (P.A.) forms that your insurance company may require in order for you to obtain their approval for prescription medication. These fee(s) must be made prior to the completion of the form(s) and the turn around time for completing form(s) is 48 hours.

(PLEASE SEE OTHER SIDE)

_____ePrescribing Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe in this manner. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, utilizing secure technology to protect the privacy of your personal information. ePrescribing software also allows our providers to see important information, such as drug interactions and your prescription history. The benefit to you: less confusion over handwritten presciptions or unclear phone calls, reduced possibility of medical errors, fewer trips to drop off at the pharmacy and a safer, faster, easier way to get your prescriptions filled.

_____Prescription Refills

Please remember to obtain prescriptions at the time of your office visit. We greatly appreciate the reduction in time and paperwork this represents. Because of medical and legal considerations, we can refill prescriptions during office hours only. ***Our office policy is not to refill prescriptions after office hours or on weekends.*** This strict policy allows us to maintain accurate records and avoid inappropriate refills. Please allow at least 24 hours turnaround for all prescriptions.

_____Financial Policy

To keep the cost of our professional services down, we are obliged to request payment at the time of service. We accept payment by check, cash and credit cards.

Copayments will be collected at the time of the office visit. We do not invoice for copays.

_____Billing Policy

Our insurance and billing office is located off-site. They are prepared to assist you with the task of filing medical insurance claims. This does not relieve you of the responsibility of paying for services at the time of your visit. Please feel free to discuss your individual policy with our business office at 256-533-7064.

I directly assign all medical/surgical benefits to Alabama Colon & Gastro, P.C. and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the Physician/Practice to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I hereby authorize any physician or hospital to provide copies of my medical history and treatment to Alabama Colon & Gastro, P.C. Photocopies of this agreement are as good as the original.

Patient Name:_____

Patient Signature:_____Date:_____

Alabama Colon & Gastro, P.C.
Release of Medical Information

Consent for use or disclosure of protected health information for payment, treatment and health care operations

I, the undersigned, as a patient OR his/her representative, do hereby authorize Alabama Colon & Gastro, P.C. to release my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim. Alabama Colon & Gastro, P.C. is also hereby authorized to release to my physician(s), wither as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes. I hereby authorize Alabama Colon & Gastro, P.C., to release any medical information to physicians other than original referring providers, who may be involved in my or my dependent's health care treatment, when requested by these physicians. By signing this consent, information will be given to requesting providers without further signed authorization. I hereby give permission to disclose, discuss and speak with personal medical information about my treatment to the below listed individuals. Unless specifically listed below, we cannot speak to any individual concerning your medical or financial information including appointments, test results, prescriptions, school or work excuses, etc. This includes your spouse, children, parents, etc. We must have each individual listed by name.

- O Release by Medical Information to the following:

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

OR

- O Restrict/DO NOT RELEASE ANY INFORMATION

You should read the Notice of Privacy Practices for PHI attached before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice. Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer).

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Alabama Colon & Gastro, P.C. or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individual(s).

Patient Name:_____

Patient Signature:_____ Date_____

As a personal representative, I have authority to act for the individual because I am the individual's _____

Alabama Colon & Gastro, P.C.

Patient Name:_____ DOB:_____Date of Visit:_____

Your Personal Medical History

Please complete the following information for your past or ongoing medical conditions.

- ❍ Allergic rhinitis
- ❍ Anal Warts
- ❍ Anxiety/Depression
- ❍ Asthma
- ❍ Barrett's Esophagus
- ❍ Bleeding Disorder
- ❍ Blood Clots
- ❍ Bowel Obstruction
- ❍ Breast Cancer
- ❍ Celiac disease or sprue
- ❍ Chronic Renal Failure Syndrome
- ❍ Colon Cancer/Colon Polyps
- ❍ Congestive Heart Failure
- ❍ COPD
- ❍ Coronary Artery Disease
- ❍ Coronary Artery Stent Placement
- ❍ Crohn's Disease
- ❍ Diabetes Mellitus
- ❍ Dialysis
- ❍ Diverticulosis
- ❍ Diverticulitis (infected diverticulosis)
- ❍ Emphysema
- ❍ Esophageal Cancer
- ❍ Esophageal Reflux Disease (GERD)
- ❍ Esophageal Stricture
- ❍ Esophageal Varices
- ❍ Fatty Liver
- ❍ Fibromyalgia
- ❍ Gastritis
- ❍ Genital herpes
- ❍ Glaucoma
- ❍ Gout
- ❍ Grave's Disease
- ❍ Hemorrhoids
- ❍ Hepatitis (type, if known_____)
- ❍ Hiatal Hernia
- ❍ History of H. pylori infection
- ❍ High blood pressure or hypertension
- ❍ Hyperlipidemia
- ❍ Inguinal Hernia
- ❍ Iron Deficiency Anemia
- ❍ Irritable Bowel Syndrome
- ❍ Ischemic Colitis
- ❍ Kidney Stones
- ❍ Liver Cancer
- ❍ Lung Cancer
- ❍ Lymphoma
- ❍ Migraine Headaches
- ❍ Osteoarthritis
- ❍ Osteoporosis
- ❍ Osteopenia
- ❍ Pancreatitis
- ❍ Pancreatic Cancer
- ❍ Pernicious Anemia
- ❍ Prostate Cancer
- ❍ Prostate Enlargement
- ❍ Rheumatoid Arthritis
- ❍ Schizophrenia
- ❍ Seizure Disorder
- ❍ Sinusitis
- ❍ Sleep Apnea (do you require C-PAP_____)
- ❍ Stomach or duodenal ulcer
- ❍ Stroke (cerebrovascular accident)
- ❍ TIA (Transient Ischemic Attack)
- ❍ Transfusion of blood or blood products
- ❍ Ulcerative Colitis
- ❍ Valvular Heart Disease
- ❍ None of the Above

Social History

- ❍ Do you use Tobacco products? Yes or No If yes, what type and how often:_____
- ❍ Do you drink Alcohol? Yes or No If yes, how many drinks per day:_____
- ❍ Do you use Recreational Drugs or Substances: Yes or No If yes, names_____
- ❍ Do you have a will or a trust? Yes or No
- ❍ Have you fallen in the past year? Yes or No: If yes, please explain:_____
- ❍ Do you feel safe at home? Yes or No

Family History

Please complete the following information for any important medical disorders that could be inherited from your close family members (father, mother, sister or brother).

Please list family member(s):

- ❍ Heart Disease_____
- ❍ Hepatitis_____
- ❍ Bleeding Disorder_____
- ❍ Pancreatic Disease_____
- ❍ Colon Polyps_____
- ❍ Ulcerative Colitis_____
- ❍ Crohn's Disease_____
- ❍ Colon Cancer_____
- ❍ Other_____

❍ **None of the above**

Alabama Colon & Gastro, P.C.

Patient Name:_____DOB:_____Date:_____

Surgical History

Please complete the following information for any surgeries you have had in the past.

Gastrointestinal

- ○ Appendectomy (removal of appendix)
- ○ Cholecystectomy (removal of gallbladder)
- ○ Colectomy or colon resection (removal of all or part of the colon)
- ○ Exploratory abdominal surgery for adhesions
- ○ Fundoplication (repair of hiatal hernia)
- ○ Gastric Bypass (weight loss surgery)
- ○ Gastrectomy or gastric resection (removal of all or part of the stomach)
- ○ Hemorrhoidectomy
- ○ Inguinal (groin) hernia repair
- ○ Splenectomy
- ○ Ventral or abdominal wall hernia repair
- ○ Whipple Procedure for Pancreatic Cancer

Cardiac

- ○ Abdominal aortic aneurysm repair
- ○ Coronary artery bypass graft
- ○ Femoral bypass
- ○ Coronary artery stent placement
- ○ Heart Valve surgery
- ○ Pacemaker Placement
- ○ Cardiac Ablation for Rhythm Disturbance
- ○ ICD Device

Transplantation

- ○ Liver Transplant
- ○ Kidney Transplant

Genitourinary

- ○ TURP (reduction of prostate gland through the penis)
- ○ Cystectomy with ileal conduit
- ○ Nephrectomy (removal of kidney)
- ○ Prostatectomy (removal of prostate gland through the abdominal wall)
- ○ Gold seed implant for prostate cancer

Gynecological

- ○ Abdominal Hysterectomy
- ○ Vaginal Hysterectomy
- ○ Oophorectomy
- ○ Cesarean Delivery
- ○ Breast Biopsy

Other

- ○ Breast augmentation
- ○ Breast reduction, both
- ○ Cataract Surgery
- ○ Glaucoma Surgery
- ○ Mastectomy (side_____)
- ○ Skin lesion, local excision
- ○ Thyroidectomy (removal of thyroid gland)
- ○ Port-A-Cath Placement

○ **None of the Above**

Gastrointestinal Procedures

Please check all that apply for any procedures you have had in the past.

○ Colonoscopy Findings:_____Year:_____

○ EGD Findings:_____Year:_____

○ Liver Biopsy Findings:_____Year:_____

○ ERCP Findings:_____Year:_____

○ EUS Findings:_____Year:_____

○ **None of the Above**

Alabama Colon & Gastro, P.C.

Patient Name:_____DOB:_____Date:_____

Medications

Please list **ALL** current medications you are taking including Vitamins, Herbals and Over the Counter Medications.

Medication	Dosage	Frequency	Reason for Taking

Medication Allergies

Medication Allergies:

O None

Latex Allergy: __No __Yes Reaction:_____

Medication	Reaction

Pharmacy Information

Please tell us the Pharmacy where you would like to use for your prescriptions.

Name of Pharmacy:_____

Address/Location of Pharmacy: _____

Phone Number of Pharmacy:_____