GASTROCARE, P.C.

DR. A.B. REDDY, M.D., F.A.C.G. DR. REKHA KHURANA, M.D.

Referring Physician: _____

First Name: _____ Last name: _____

Date of Birth: _____ Age: _____

Pharmacy (include location): _____ Fax Number: _____

Email Address: _____

Gender: Male Female

Race: American Indian / Alaskan Native / Asian / African American / Caucasian / More than one race / Pacific Islander / Refused

Ethnicity: Hispanic / Latino / Non-Hispanic / Declined

Language: English / Spanish / Other

Contact Preference: HOME: _____ Cell #: _____ Office #: _____

REASON FOR VISIT: _____ _____

_____

Allergies: _____ _____

_____ _____

Current Medications (Name/Dose/How taken): _____

_____ _____

_____ _____

_____ _____

Diagnostic Studies/Tests: _____ _____

_____ _____

_____ _____

_____ _____

Past or Present Medical Conditions:

Cancer:	Yes	No	Type:_____
Peptic Ulcer:	Yes	No	
Heart Attack:	Yes	No	
Diabetes:	Yes	No	
High Blood Pressure:	Yes	No	
Hepatitis:	Yes	No	Type:_____
Stroke:	Yes	No	
Emphysema:	Yes	No	
Seizures:	Yes	No	
Colon Polyps:	Yes	No	
Ulcerative Colitis/Crohns:	Yes	No	
HIV:	Yes	No	
Thyroid Problems:	Yes	No	

Gastrointestinal Symptoms:

None:	Yes	No
Black Stool:	Yes	No
Difficulty Swallowing:	Yes	No
Loss of appetite:	Yes	No
Abdominal Pain:	Yes	No
Abdominal Swelling:	Yes	No
Change in bowel habits:	Yes	No
Constipation:	Yes	No
Diarrhea:	Yes	No
Gas:	Yes	No
Heartburn/reflux:	Yes	No
Jaundice:	Yes	No
Nausea:	Yes	No
Rectal bleeding/blood in stool:	Yes	No
Stomach Cramps:	Yes	No
Vomiting:	Yes	No
Blood in vomit:	Yes	No
Weight Loss:	Yes	No

Review of Systems:

Allergic/Immunologic:
HIV exposure Yes No

Cardiovascular:
Chest Pain Yes No
Dyspnea with exercise Yes No
Irregular heart beat Yes No
Palpitations Yes No

Constitutional:
Fatigue Yes No
Fever Yes No
Loss of appetite Yes No
Weight loss Yes No

ENMT:
Ear pain Yes No
Nose bleeds Yes No
Photophobia Yes No
Sore throat Yes No

Endocrine:
Excessive thirst Yes No
Diabetes Yes No

Genitourinary:
Frequent urination Yes No
Difficulty urinating Yes No
Blood in urine Yes No

Integumentary:
Allergies Yes No
Dryness Yes No
Hives Yes No
Jaundice Yes No
Rashes Yes No

Musculoskeletal:
Arthritis Yes No
Lupus Yes No
Fibromyalgia Yes No

Neurological:
Frequent headaches Yes No
Seizures Yes No

Respiratory:
Asthma Yes No
Cough Yes No
Dyspnea Yes No

Psychiatric:
Anxiety Yes No
Depression Yes No
Difficulty sleeping Yes No
Nervousness Yes No
Stress factors Yes No

Previous Procedures/Surgeries: _____

_____

_____

Social History:
Occupation: _____

Marital Status: Single / Married / Divorced / Widowed
Alcohol: None | Duration:_____ Type:_____ Quantity: _____ Frequency: _____
Caffeine: None | Duration:_____ Type:_____ Quantity: _____ Frequency: _____

Tobacco:
Current Every Day Smoker / Former Smoker / Never Smoked / Chew Tobacco
Quantity: _____ How long: _____

Recreational Drug Use: Never / In Past / Current Use If yes, type: _____

Family Medical History: Family history noncontributory Yes No

	Type:	Relationship:
Colon Cancer	_____	_____
Ulcerative Colitis/Crohn's	_____	_____
Family history of Colon polyps	_____	_____
Liver Disease/Cirrhosis	_____	_____
Esophageal Cancer	_____	_____
Stomach Cancer	_____	_____
Other Cancers, type	_____	_____

GASTROCARE, P.C. / TUSCALOOSA ENDOSCOPY CENTER
PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

Basic Patient Information

Patient's Social Security Number: _____

Name of Patient: _____
First Middle Last

Date of Birth: _____ Gender: M ☐ F ☐

Street Address: _____

City: _____ State: _____ Zip: _____

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

Billing Information / Responsible Party / Guarantor for Encounter

Responsible Party: _____
(If different from patient) First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Responsible Party's SSN: _____ Gender: M ☐ F ☐

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

Responsible Party's Employer: _____

Insurance Coverage Primary

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

Name of Insurance: _____ Policy Number: _____

Group Name: _____ Group Number: _____

Co-pay Amount: _____ Effective Date: (if applicable) _____

Patient's Relationship to Policyholder: Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other ☐

Name of Policyholder: _____
(If different from Responsible Party) First Middle Last

Birth Date of Policyholder: _____ Retire Date: (if applicable) _____

Phone Number: ( ) _____ Gender: M ☐ F ☐

Name of Policyholder's Employer: _____

Address of Insurance Holder: _____
(if different than Responsible Party Information)

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION CONTINUED

Insurance Coverage Secondary

Name of Secondary Insurance: _____ Policy Number: _____

Group Name: _____ Group Number: _____

Effective Date: _____ Expiration Date: _____

Patient's Relationship to Policyholder: Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other ☐

Name of Policyholder: _____
(If different from Responsible Party) First Middle Last

Birth Date of Policyholder: _____ Retire Date: (if applicable) _____

Phone Number: ( ) _____ Gender: M ☐ F ☐

Name of Policyholder's Employer: _____

Address of Insurance Holder: _____
(if different than Responsible Party Information)

City: _____ State: _____ Zip: _____

Additional Patient Information

Referring Physician: _____

Did you bring with you today the written referral form from your Referring Physician? Yes ☐ No ☐

Primary Care Physician: _____

Emergency Contact Information – Primary Contact

Please provide an alternative phone number if person lives in the same household

Name: _____ Relationship to Patient: _____

Home Phone: ( ) _____ Secondary Phone Number: ( ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

Notes / Special Directions: _____

Financial Responsibility Agreement

I/We hereby authorize GASTROCARE, P.C. / TUSCALOOSA ENDOSCOPY CENTER to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above names patient. I/We authorize payment of medical benefits to GASTROCARE, P.C. / TUSCALOOSA ENDOSCOPY CENTER and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I/We hereby authorize GASTROCARE, P.C. / TUSCALOOSA ENDOSCOPY CENTER to act on my behalf in accessing hospital records when and if needed.

_____ _____

Date Patient or Guardian Signature

GASTROCARE, P.C. (GRC) AND
TUSCALOOSA ENDOSCOPY CENTER (TEC)

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I (we), the undersigned patient and/or responsible party hereby authorize GASTROCARE, P.C. / TUSCALOOSA ENDOSCOPY CENTER, it's physician's, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc to the person or persons indicated below:

_____ Spouse Name _____

_____ Parent(s) Name(s) _____

_____ Children Name(s) _____

_____ Other Name(s) _____

May we leave medical information on you answering machine? YES / NO

May we release medical information to an individual about your procedure, if they come with you for a procedure? YES / NO

Patient Signature: _____ Date: _____

******* _____ **DO NOT DISCUSS OR RELEASE ANY OF MY MEDICAL INFORMATION TO ANYONE EXCEPT MYSELF.**

GASTROCARE, P.C. AND

TUSCALOOSA ENDOSCOPY CENTER

A.B. REDDY, M.D., F.A.C.G. REKHA KHURANA, M.D.

AUTHORIZATION FOR TREATMENT

The undersigned has been informed of the treatment considered necessary for the patient whose name appears on the bottorn and that the treatment and procedures will be performed by the above physicians, and whomever he may designate as assistants. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance is made as to the results that may be obtained.

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient or Authorized Person Witness

_____
Relationship to Patient

****

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted to release to the Primary or Consulting / Referring Physician such information as may be necessary for the completion of my hospitalization claims.

_____
Signature of Patient or Authorized Person

_____
Relationship to Patient

****

AUTHORIZATION TO PAY THE PHYSICIAN / FACILITY

I hereby authorize payment for services provided in the office, endoscopy center and the hospital directly to the above physician, otherwise payable to me. I understand I am financially responsible for the medical and/or physician charges not covered by this authorization.

_____
Signature of Patient or Authorized Person

_____

Relationship to Patient

All authorizations must be signed by the patient or by an authorized person in the case of a minor or when a patient is physically or mentally incompetent.

ACKNOWLEDGMENT & CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from GASTROCARE, P.C. (GRC) / TUSCALOOSA ENDOSCOPY CENTER (TEC). You agree that records concerning your care within GRC and/or TEC shall remain the property of TEC and/or GRC. You understand and agree that such information is used for: (1) your treatment – the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient, (2) payment for your services – billing, claims management, medical data processing, reimbursement, and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account, (3) routine healthcare operations – including, but not limited to, quality assurance, utilization review, medical review, internal auditing, medical research and educational purposes. You acknowledge that you have been provided with a GRC/TEC Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand GRC/TEC reserves the right to change the Notice and GRC/TEC will provide you with a revised Notice when you come to TEC/GRC. You have the right to request we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____

TEC/GRC: Agree _____ Do Not Agree _____ N/A _____

_____ _____

Signature of Patient Date

Tuscaloosa Endoscopy Center

I_____ have received notification orally and in writing, prior to my day of procedure that informed (in a language I understand) me of my rights and responsibilities, the Center's policy of not honoring Advanced Directives and that Dr. A.B. Reddy is the owners of the Tuscaloosa Endoscopy Center.

I have been given the opportunity to request more information and to ask questions.

_____
Signature

_____
Date

_____
Witness

Tuscaloosa Endoscopy Center

Dear Patient,

Our staff sincerely hopes that your visit with us is pleasant and that we meet your expectations. If you have not received one of our procedure information brochures, you may pick up one in our waiting area or ask our receptionist.

The Center was established and built by Dr. Adisesha B. Reddy to serve his patients more effectively and he remains the sole owner of Tuscaloosa Endoscopy Center.

It is part of our Vision and Philosophy to provide you with high quality, efficient outpatient surgical services. As part of that Vision and Philosophy, we request that you share any concerns or compliments that affect your care here at the Center. Each compliment or concern will be followed up in a timely manner.

Because of the Nature of our center and because each procedure is elective, Tuscaloosa Endoscopy Center does not honor Advanced Directives. If you have an Advanced Medical Directive please bring a copy with you on the day of your procedure so that we will have it for our records. If you require and want information on Advanced Directives please see a TEC employee and they will be happy to give you that information.

Attached to this letter you will find your patient rights and your responsibilities. If you at anytime feel that we are not upholding your rights please ask to speak to our Director of Nursing or their designee.

Please contact our billing department at 205 345 0012 if you have any questions about your insurance or financial arrangements prior to your procedure.

Again the employees of TEC thank you for allowing us to serve your Endoscopy needs.

Sincerely,

TEC Endoscopy

Patients and families are our number one concern. It is a priority at the Tuscaloosa Endoscopy Center that patients and families are as comfortable as possible during their stay at the center. The following patient rights and responsibilities are presented as a policy for the Tuscaloosa Endoscopy Center but do not presume to be a complete representation of all mutual rights and responsibilities.

Patients Have The Right

- To reasonable access to the medical resources at the Tuscaloosa Endoscopy Center without regard to race, color, national origin, age, sex, disability, or financial status.
- To receive considerate, respectful, compassionate care that recognizes your personal values and beliefs.
- To be informed about and to participate in decisions regarding your care, including the refusal of treatment.
- To be involved in all aspects of care and to be allowed to participate in the care and to designate another person to act in your behalf.
- To voice complaints about your care and to have those complaints reviewed and, when possible, resolved. You have the right to voice your complaint to any representative of the Center or directly to the administrator. You also have the right to contact the Alabama Department of Public Health at (800) 356-9596 or at their website, www.adph.org, or the Medicare Ombudsman at the Alabama State Health Insurance Assistance Program or by telephone at (800) 243-5463 or through CMS website: www.cms.hhs.gov/center/ombudsman.asp.
- To have access to communicate with organization leaders if an ethical, cultural, or spiritual dilemma presents.
- To information about Advance Directives that would allow you to make your own healthcare decisions for the future and to have your chosen representative exercise these rights for you if you are not able to do so.
- **However, regardless of an Advance Directive formulated by a patient, it is the policy of the Tuscaloosa Endoscopy Center to resuscitate and transfer patients to a nearby hospital. Any patient who presents an Advance Directive or who indicates a desire to prepare an Advance Directive will be informed of this policy and, if requested, provided with available literature.**
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of your action.
- To have clinical and educational information about your treatment in language and terms that you understand.
- To change their provider if other qualified providers are available.
- To information about any research activities that involve your treatment, including benefits and risks, procedures involved, and alternative treatments.
- To security, privacy, and confidentiality in all patient areas as you undergo tests or treatment.
- To know who is responsible for providing your immediate direct care.
- To information about the financial aspects of services and alternative choices.
- To be supported in accessing protective services when requested.
- To appropriate pain assessment and management of pain. While pain can be a common part of the patient experience, unrelieved pain can have adverse physical and psychological effects.
    - All patients will be assessed for pain on admission and throughout their stay.
    - Patients should not hesitate to ask for medication to ease pain when it first begins or increases.

Patients Have The Responsibility

- To give your doctor and the surgery center staff complete and accurate information about your condition and care, including the reporting of unexpected changes in your condition to your physician and nurse.
- To advise your nurse, physician, or other caregiver if you do not understand the treatment course or decisions about your care.
- To follow the orders and instructions given by your doctor and instructions given by the staff for your care, including keeping follow-up appointments after discharge.
- To report unexpected changes in your condition to your physician and nurse.
- To show consideration for other patients by following all rules and instruction pertaining to smoking, visitors, noise, and general conduct.
- To accept the financial obligations associated with your care.
- To be considerate of staff members who are caring for you. A mutual spirit of respect and cooperation allows us to serve you best.
- To provide a responsible adult to remain with the patient while in the facility and to transport him or her home and a responsible adult to remain with him or her for 24 hours if required by his or her provider.