

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 <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/>	
Name of Policyholder: _____ (If different from Responsible Party) First Middle _____ Last _____	
Birth Date of Policyholder: _____	Retire Date: (if applicable) _____
Phone Number: () _____	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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

ACKNOWLEDGMENT & CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from GAST ROCARE, 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

**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.

Name: _____ Age: _____ Date: _____

Reason for your visit to our office: _____

Duration of your problem: _____

COMPLAINTS

Location, qualify, factors, associated with or affecting the problem / symptoms:

Abdominal pain: Yes/No
Weight loss: Yes/No
Diarrhea: Yes/No
Constipation: Yes/No
Nausea: Yes/No
Vomiting: Yes/No
Blood in vomitus: Yes/No
Heartburn / reflux: Yes/No
Loss of appetite: Yes/No
Black stool: Yes/No
Blood in stool: Yes/No
Difficulty in swallowing: Yes/No

PAST HISTORY	YEAR	FAMILY HISTORY	RELATIONSHIP
Cancer:	Yes/No _____	Cancer:	Yes/No _____
Peptic ulcers:	Yes/No _____	Peptic ulcers:	Yes/No _____
Hepatitis:	Yes/No _____	Diabetes:	Yes/No _____
Diabetes:	Yes/No _____	Cirrhosis/liver problems:	Yes/No _____
High blood pressure:	Yes/No _____	Heart disease:	Yes/No _____
Heart attack:	Yes/No _____	Emphysema:	Yes/No _____
Stroke:	Yes/No _____	Gallbladder disease:	Yes/No _____
Emphysema:	Yes/No _____	Colon polyps:	Yes/No _____
Seizures:	Yes/No _____	Ulcerative colitis/crohns:	Yes/No _____
Colon polyps:	Yes/No _____	High blood pressure:	Yes/No _____
Ulcerative colitis/crohns:	Yes/No _____		
Operations/Surgeries:	Yes/No _____		

Please list surgeries: _____

Have you had any blood transfusions? Yes/No If yes, explain: _____

**GASTROCARE, P.C. AND
TUSCALOOSA ENDOSCOPY CENTER**
Tuscaloosa, Alabama

A.B. Reddy, M.D., F.A.C.G., Henri de la Baume, M.D.

AUTHORIZATION FOR TREATMENT

The undersigned has been informed of the treatment considered necessary for the patient whose name appears on the bottom and that the treatment and procedures will be performed by the above physician, 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 has been made as to the results that may be obtained.

Date	Printed Name of Patient
Witness	Signature of Patient or Authorized Person
	Relationship to Patient

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**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                   |

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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.