

# 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 <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/> |        |  |            |
| Name of Policyholder: _____<br>(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: _____<br>(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 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

**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., Peter D'sa, M.D., F.A.C.G.,  
Henri de la Baume, M.D., and Chad Sisk, D.O.**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ Duration: \_\_\_\_\_

**HPI:** Abdominal Pain: (location, severity, duration, modif. Factors) Yes No

|               |     |    |                   |     |    |                        |     |    |
|---------------|-----|----|-------------------|-----|----|------------------------|-----|----|
| Weight Loss:  | Yes | No | Vomiting:         | Yes | No | Black Stool / Melena:  | Yes | No |
| Diarrhea:     | Yes | No | Blood in Vomitus: | Yes | No | Blood in Stool:        | Yes | No |
| Constipation: | Yes | No | Heartburn:        | Yes | No | Difficulty swallowing: | Yes | No |
| Nausea:       | Yes | No | Loss of Appetite: | Yes | No |                        |     |    |

**Pertinent (Your) Past Medical History:**

Cancer: Yes No      Colon polyps: Yes No      Peptic Ulcer: Yes No

Any other medical problems: Yes No      Please list: \_\_\_\_\_

Any recent hospital admissions: Yes No

**Operations:** \_\_\_\_\_

**Family History:**

Cancer: Yes No      Colon polyps: Yes No      Peptic Ulcer: Yes No

Any other medical problems: Yes No      Please list: \_\_\_\_\_

**Social History:**

Smoking: Yes No      Alcohol Use: Yes No

**ALLERGIES:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**ROS:**

|                  |                             |     |    |                        |       |    |                    |     |    |
|------------------|-----------------------------|-----|----|------------------------|-------|----|--------------------|-----|----|
| Constitutional:  | Appetite:                   | Yes | No | Weight Gain:           | Yes   | No | Fever:             | Yes | No |
| Cardiovascular:  | Chest pain:                 | Yes | No | Irregular Heart:       | Yes   | No | Coughing up blood: | Yes | No |
| Respiratory:     | Shortness of Breath:        | Yes | No | Cough:                 | Yes   | No | Kidney stone:      | Yes | No |
| Genitourinary:   | Difficulty Urinating:       | Yes | No | Blood in Urine:        | Yes   | No |                    |     |    |
| Endocrine:       | Diabetes:                   | Yes | No |                        |       |    |                    |     |    |
| Psychological:   | Stress Factors:             | Yes | No |                        |       |    |                    |     |    |
| Musculoskeletal: | Arthritis:                  | Yes | No | Lupus:                 | Yes   | No | Fibromyalgia:      | Yes | No |
| Gynecological:   | Menses: Regular / Irregular |     |    | Last Menstrual Period: | _____ |    | Endometriosis:     | Yes | No |

CNS:

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

**A.B. Reddy, M.D., F.A.C.G., Peter D'sa, M.D., F.A.C.G.,  
Henri de la Baume, M.D., and Chad Sisk, D.O.**

**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.