Gastroenterology Associates of Gainesville, P.C.

PATIENT REGISTRATION FORM

MRN: _____

DATE:	**REASON FOR VISIT:**		
LAST NAME	FIRST NAME		MIDDLE NAME
SOCIAL SECURITY #	SEX	I IDENTIFY MYSELF AS:	BIRTH DATE: (MM/DD/YYYY)
MAILING ADDRESS:	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	MOBILE PHONE	E-MAIL ADDRESS
MARTIAL STATUS	INTERPRETER NEEDED?	PREFERRED LANGUAGE	RACE / ETHNICITY
RELIGION	COMMUNICATION PREFERENCE	PRIMARY CARE PHYSICIAN	

EMPLOYER INFORMATION

PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE
BUSINESS ADDRESS	CITY / STATE	ZIP

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	MOBILE PHONE

GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OLD)

GURANTOR'S NAME	RELATIONSHIP	SOCIAL SECURITY #
ADDRESS (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH	SEX
EMPLOYER	HOME PHONE / WORK PHONE	MOBILE PHONE
EMPLOYER'S ADDRESS	CITY / STATE	ZIP
NAME OF ADULT PRESENTING MINOR FOR TREATMENT		RELATIONSHIP

INSURANCE INFORMATION

INSURANCE COMPANY (PAYOR)	SUBSCRIBER ID	GROUP ID
SUBSCRIBER NAME	DATE OF BIRTH / SOCIAL SECURITY #	PATIENT RELATIONSHIP TO SUBSCRIBER
SECONDARY INSURANCE	SUBSCRIBER ID	GROUP ID
SUBSCRIBER NAME	DATE OF BIRTH / SOCIAL SECURITY #	PATIENT RELATIONSHIP TO SUBSCRIBER

REFERRAL INFORMATION

REFERRED BY:	
HOW DID YOU HEAR ABOUT OUR OFFICE?	

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of Gastroenterology Associates of Gainesville, P.C.and its affiliates, agents, contractors, or business associates. I understand that the health insurance coverage I have provided is the insurance(s) in which will be filed.

Patient Signature:		**Date:**	
Parent/Legal Representative Signature:		**Date:**	
Parent/Legal Representative Print Name:		**Relationship:**	

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE

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ANNUAL CONSENT/AUTHORIZATIONS **MRN: _____**

Consent for Treatment

- Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, Nurse Practitioner, or Nurse Midwife.
- I understand I have the right to see a Physician, if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

Consent to Release Medical Information to a Spouse, Family Member or Significant Other

Tell us with whom we may discuss your protected health information: *(Name and relation. Example: Jane Doe, Wife; Jan Doe, Daughter)*

1) Name: _____ Relationship: _____ Phone #: _____
2) Name: _____ Relationship: _____ Phone #: _____
3) Name: _____ Relationship: _____ Phone #: _____

This authorization and all other agreements on this form shall remain in effect until revoked by me in writing. An electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization at any time.

If you do not authorize information to be released to anyone, please check this statement.
□ I do not authorize any information to be released to anyone other than myself.

Financial Responsibility

I understand it is the responsibility of each patient to arrange for payment for the medical services received. I hereby authorize any insurance benefits to be paid directly to Northeast Georgia Physicians Group, Gastroenterology Associates of Gainesville, P.C. and any of their affiliates, agents, contractors or business associates and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

I hereby authorize Northeast Georgia Physicians Group, Gastroenterology Associates of Gainesville, P.C. or any of their affiliates, agents, contractors or business associates, to contact me and I hereby authorize messages to be left on a voicemail system or answering machine (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received by Gastroenterology Associates of Gainesville, P.C., or any of its affiliates, agents, contractors or business associates or the payment for the services I received by Gastroenterology Associates of Gainesville, P.C., or any of its affiliates, agents, contractors or business associates including but not limited to, debt collection purposes.

Acknowledgement of Receipt of Nondiscriminatory Act Notice		**Initials**

By initialing, I acknowledge that I am aware of the Nondiscriminatory Act Notice and have the right to be provided with a copy of the notice upon my request.

Acknowledgement of Privacy Rights		**Initials**

By initialing, I acknowledge that I am aware of the NGHS/Gastroenterology Associates of Gainesville, P.C.Notice of Privacy Practices and Individual Rights and have the right to be provided with a copy of the notice upon my request. We may use or share your medical information with personnel involved in your care at the practice. We may also disclose your medical information to people outside of the System, such as Health Information Exchanges. The Notice of Privacy Practices contains more information about the policies and practices protecting the patient's privacy.

I acknowledge that I have read the above, am giving my consent to all of the above, and have been informed of my rights to privacy.

Patient Signature:		**Date:**	
Parent/Legal Representative Signature:		**Date:**	
Parent/Legal Representative Print Name:		**Relationship:**	
Patient Print Name:		**Patient DOB:**	

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POLICIES ACKNOWLEDGEMENT

MRN: _____

Please read over our policies below and initial where required.
Your initials tell us that you agree to comply with these policies.

Payment Policy		**Initials**

1. In compliance with new Federal law, we will ask you for photo identification and proof of health insurance at every visit. We may also take your picture the first time you visit our office.
2. It is not feasible for our staff to be fully aware of each health insurance plan's specific requirements or coverages. We will do everything we can to help you; however, it is your responsibility to verify that Northeast Georgia Physicians Group, Gastroenterology Associates of Gainesville, P.C. and their affiliates, agents, contractors or business partners are part of your insurance plan's covered providers, and to know what your plan does and doesn't cover.
3. It is your responsibility to know what limitations your insurance plan may place on the number of times you can be seen in the office, have treatments performed, when referrals are required to receive care, or receive other types of health care.
4. Gastroenterology Associates of Gainesville, P.C. and Northeast Georgia Physicians Group are contractually obligated to collect applicable co-payments at the time of services are rendered. We are also obligated to collect any deductible and/or co-insurance amounts deemed patient responsibility by your insurance.
5. Any charges you incur with us that are not paid by your health insurance according to our existing agreements will be your responsibility to pay. We will bill your insurance plan as a courtesy to you.
6. Please be aware Gastroenterology Associates does not process billing for, anesthesia, labs, most physician services, most pathology, and facility charges. You may receive statements from other affiliates, agents, contractors, or business associates. Any questions regarding those charges would need to be directed to their office.
7. If you do not have health insurance, we will be happy to provide care for you. We offer a discount to uninsured patients on those services that would typically be billed to an insurance company. In order to qualify for this discount, we require a minimum time of service deposit of $100.00 to be paid at check-in. This payment will be applied towards any charges for your visit. If you are not able to make the minimum payment at check-in, you will be asked to reschedule your appointment unless you have an urgent need to be seen. If there is an overpayment, outstanding balances will be settled before a refund can be issued.
8. We will continue to provide care for you while you are paying off any outstanding balances owed. You will need to pay in full any charges you incur at the time of service while you are paying off outstanding balances. An exception may be made if your provider determines your visit is urgently needed. If you are unable to pay in full at the time of service, please ask about our payment options.
9. We do use a collection agency for accounts that fail to make a good faith effort to pay for the medical services we provide.

Prescription Refill Policy		**Initials**

Please allow 48 hours for all prescription refills. To speed up the process, please ask your pharmacy to send a refill request to the clinic.

Medical Records Policy		**Initials**

We are happy to provide you with a copy of your medical records. You must first provide a properly verified signed release of information for copies provided via email, CD, or on paper. A cost may be associated depending on the number of pages requested.

Center for Advanced Research & Education (CARE) Notice		**Initials**

Our practice has partnered with CARE Research in Gainesville to provide access for our patients to new diagnostic/treatment options at no cost to you or your insurance. Some of these services are performed at our facility by Gastroenterology Associate providers. If you are a candidate, CARE will contact you to provide further information. **Check YES to opt in or NO to decline. □ YES □ NO**

Changes in your Personal Information		**Initials**

You are responsible for informing us of any changes to your name, address, telephone number, email address, or health insurance coverage. Failure to do so may affect your insurance coverage and/or our ability to provide you with important information about your health. Any insurance denials received due to inaccurate information will be the patient's responsibility.

I acknowledge that I have read the above, am giving my consent to all of the above.

Patient Signature:		**Date:**	
Parent/Legal Representative Signature:		**Date:**	
Parent/Legal Representative Print Name:		**Relationship:**	
Patient Print Name:		**Patient DOB:**	

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MEDICAL INFORMATION SHEET

MRN: _____

PATIENT NAME	DATE OF BIRTH	DATE
		10/9/2024

PRIMARY CARE PHYSICIAN	REFERRING PROVIDER
<<P	<<

REASON FOR VISIT	WHERE IS THE PROBLEM LOCATED	FOR HOW LONG

DOES ANYTHING MAKE IT BETTER	DOES ANYTHING MAKE IT WORSE

PHARMACY:	PHARMACY LOCATION:

HAVE YOU HAD PAST SURGERIES? □ YES □ NO IF YES, PLEASE LIST WHAT KIND AND WHEN BELOW:

HAVE YOU HAD A FLU SHOT IN THE PAST YEAR? □ YES □ NO IF YES, WHAT MONTH AND YEAR?

HAVE YOU HAD A PNEUMONIA SHOT? □ YES □ NO IF YES, WHAT YEAR?

HAVE YOU EVER SMOKED?	□YES □ NO	**DO YOU CURRENTLY SMOKE?**	□YES □ NO
HAVE YOU EVER CONSUMED ALCOHOL?	□YES □ NO	**DO YOU CURRENTLY DRINK ALCOHOL?**	□YES □ NO
HAVE YOU EVER USED INJECTION OR RECREATIONAL DRUGS?	□YES □ NO	**DO YOU CURRENTLY USE DRUGS?**	□YES □ NO

DOES YOUR FAMILYHAVE A HISTORY OF THE FOLLOWING CANCERS? IF SO WHO?

COLON	□YES □ NO	WHO		LIVER	□YES □ NO	WHO	
STOMACH	□YES □ NO	WHO		PANCREAS	□YES □ NO	WHO	
BREAST	□YES □ NO	WHO		OVARIAN	□YES □ NO	WHO	
UTERINE	□YES □ NO	WHO		BRAIN	□YES □ NO	WHO	

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

HEADACHES	□YES □ NO	DIZZINESS	□YES □ NO	NUMBNESS/TINGLING	□YES □ NO
FEVER/CHILLS	□YES □ NO	CHEST PAIN	□YES □ NO	SWOLLEN LYMPH NODES	□YES □ NO
BLURRED/DOUBLE VISION	□YES □ NO	SHORTNESS OF BREATH	□YES □ NO	SWOLLEN GLANDS	□YES □ NO
BLEEDING GUMS	□YES □ NO	SORE THROAT	□YES □ NO	DIFFICULT/BLOODY URINE	□YES □ NO
ABDOMINAL PAIN	□YES □ NO	CHANGE IN APPETITE	□YES □ NO	NAUSEA	□YES □ NO
REFLUX/HEART BURN	□YES □ NO	EXCESSIVE GAS	□YES □ NO	VOMITING	□YES □ NO
DIFFICULTY SWALLOWING	□YES □ NO	LOOSE STOOLS	□YES □ NO	BLOATING	□YES □ NO
BLOOD ON TOILET PAPER	□YES □ NO	BLOOD IN STOOL	□YES □ NO	HARD STOOLS	□YES □ NO

CHANGE IN WEIGHT? □YES □ NO IF YES, PLEASE EXPLAIN:

CHANGE IN COLOR, SHAPE, CONSISTENCY OF STOOL? □YES □ NO IF YES, PLEASE EXPLAIN:

DO YOU HAVE A HISTORY OF OR HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

HIGH BLOOD PRESSURE	□YES □ NO	CHRONIC BACK PAIN	□YES □ NO	SEIZURES	□YES □ NO
DIABETES	□YES □ NO	ARTHRITIS	□YES □ NO	GLAUCOMA	□YES □ NO
HIGH CHOLESTEROL	□YES □ NO	STROKE	□YES □ NO	CATARACT	□YES □ NO
SLEEP APNEA	□YES □ NO	DEPRESSION	□YES □ NO	THYROID DISORDER	□YES □ NO
COPD/EMPHYSEMA/ BRONCHITIS	□YES □ NO	HEPATITIS	□YES □ NO	BLOOD CLOTS (LUNGS/LEGS)	□YES □ NO
FIBROMYALGIA	□YES □ NO	JAUNDICE	□YES □ NO	CANCER	□YES □ NO
BLEEDING DISORDER	□YES □ NO	KIDNEY DISEASE	□YES □ NO		
OTHER DISORDERS		ANY HEART CONDITION			

DO YOU HAVE ANY IMPLANTED DEVICES? PACEMAKER, DEFIBRILLATOR, MUSCLE STIMULATOR, OTHER:

FEMALE PATIENTS ONLY	REGULAR MENSTRUAL PERIODS? □YES □ NO	TYPE OF CONTRACEPTION:	HISTORY OF HEAVY/FREQUENT BLEEDING? □YES □ NO

PATIENT SIGNATURE:		**DATE**	
PARENT/LEGAL REPRESENTATIVE SIGNATURE:		**DATE:**	
PARENT/LEGAL REPRESENTATIVE PRINT NAME:		**RELATIONSHIP:**	

Revised 10/09/2024