East Tennessee
Gastroenterology
PLLC

Patient information

First Name: _____ Middle: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different than above): _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____

Date of Birth: _____ Social Security Number: _____ Sex: Male Female

Marital Status: __ Single __ Married __ Widowed __ Divorced __ Separated

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Primary Care Physician: _____

Additional Physicians: _____

_____

Primary Insurance: _____ Secondary Insurance: _____

Consent to Import Medication History: I consent to obtaining a history of my prescription medications purchased at pharmacies. ___Yes ___No

Consent to Share Data: I consent to having my medical and demographic information shared with other physicians and health care entities if needed. ___ Yes ___No

Reminder Preference: I would like to receive preventative care and follow up care reminders. ___ Yes ___ No

_____ _____

Patient/Guardian Signature Date

Privacy Options: In some cases, it is not possible to reach our patients during working hours to discuss test results, future appointments, and account balances. Your response to the questions below will give us guidance when we cannot contact you personally.

George A. Samuel, D.O.
2404 Chambliss Avenue, Cleveland, TN 37311
423.339.2000 • Fax 423.339.2043 • www.etgastro.com

1. We may leave a message, either on your answering machine or with the person answering your phone regarding appointments? ____Yes ____No

2. May we speak with other people regarding your insurance, billing questions or financial arrangements? ___ Yes ___No If yes, to whom may we speak? _____

3. May we speak with other people regarding test results or other medical information?

___Yes ___NO If yes, to whom may we speak? _____

My signature indicates that I have received the "Notice of Privacy Policies" for East Tennessee Gastroenterology, PLLC.

_____ _____

Patient/Guardian Signature Date

****

Authorizations: Below, you will find several specific authorizations or consents that we are required to have. Some of these are required by law, and others by Medicare or your insurance company, so that we can properly process your claims for payment. If you do not understand any part of this, please ask us and we will try to explain it to you more clearly.

You agree to permit your protected health information to be used and disclosed for purposes of treatment, payment and health care operations. For more details about these uses and disclosures, please see our Privacy Notice.

We reserve the right to change our privacy policies described in the Privacy Notice. You may call us to receive an updated Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree with this request, but if we do, we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use or disclosure of your information.

I understand that charges for professional services not covered by insurance are due and payable at each visit. I also understand that my health insurance is a contract between myself and my insurance carrier, and not between my insurance carrier and the physician, and I hereby assume full responsibility for all charges incurred for professional services rendered by the physicians of East Tennessee Gastroenterology, PLLC, unless the services are deemed "paid in full" as a result of a contractual agreement between East Tennessee Gastroenterology, PLLC and my insurer. If my insurance company has not paid their portion within 60 days of being properly billed, I understand that the balance will become due and payable from me.

********WE CHARGE A $25.00 NO SHOW FEE FOR MISSED OFFICE VISITS NOT CANCELLED IN ADVANCED. WE CHARGE A $100.00 FEE FOR OFFICE PROCEDURES THAT ARE NOT CANCELLED BY 12:00PM ON THE THURSDAY PRIOR TO THE MONDAY PROCEDURE. WE CHARGE $100.00 FOR OFFICE PROCEDURES NOT CANCELLED 48HRS IN ADVANCE IF SCHEDULED ON WEDNESDAY.**

In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection agency costs and reasonable attorney fees incurred to effect collection on this account.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CCHS) or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I request that payment of authorized insurance benefits to be made either to me or on my behalf to any services furnished me by this physician or supplier. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand I am financially responsible to said physician for any balance not covered by my insurance carrier.

_____ _____

Patient/Guarantor Signature Date

East Tennessee Gastroenterology PLLC

2404 Chambliss Ave.
Cleveland, TN 37311
Phone: 423.339.2000
Fax: 423.339.2043

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Email

Personal:_____

Race

Select one or more

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown
- ☐ Patient declines to specify
- ☐ Prohibited by state law

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to specify
- ☐ Prohibited by state law

Sex

- ☐ Male
- ☐ Female
- ☐ Other

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies

Other:_____

Current Medications

- ☐ None

Name	Dose	How taken?

Printed on 9/13/2017

Immunizations

- ☐ None
- ☐ Hep A, adult — When:_____
- ☐ Hep B, adult — When:_____
- ☐ Hep C — When:_____
- ☐ Pneumonia — When:_____
- ☐ Flu — When:_____

Diagnostic Studies/Tests

- ☐ None
- ☐ Colonoscopy — When:_____
- ☐ EGD — When:_____
- ☐ Abdominal U/S — When:_____
- ☐ CT Scan — When:_____
- ☐ MRI of the abdomen — When:_____
- ☐ HIDA Scan — When:_____

Past or Present Medical Conditions

- ☐ None

Esophagus	☐ Acid Reflux	☐ Narrowing of Esophagus	☐ Achalasia	☐ Esophageal Cancer
Stomach	☐ Gastric ulcers	☐ H pylori	☐ Stomach Cancer	☐ Gastroparesis
Colon	☐ Colon Polyps ☐ Colon Cancer	☐ Diverticulitis	☐ Ulcerative colitis	☐ Crohns
Rectum	☐ Hemorrhoids	☐ Fistulas	☐ Rectal Cancer	
Liver	☐ Hepatitis A/ B/ C	☐ Cirrhosis	☐ Abnormal Liver blood tests	
Gallbladder	☐ Gallstones	☐ gallbladder disease	☐ biliary cancer	
Pancreas	☐ Pancreatitis	☐ pancreatic cysts	☐ Pancreatic Cancer	
Other	☐ Celiac Disease	☐ Irritable bowel syndrome	☐ Cdifficile infection	
Other Non GI	☐ Diabetes	☐ High Blood Pressure	☐ Heart conditions	Other:_____
	Other:_____	Other:_____	Other:_____	Other:_____

Previous Procedures

- ☐ None
- ☐ Gallbladder
- ☐ Appendix
- ☐ Colon Surgery
- ☐ Gastric/esophageal Surgery
- ☐ Hysterectomy
- ☐ Cardiac Surgeries
- ☐ C-Section
- ☐ Mastectomy
- ☐ Hemorrhoidectomy
- Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- ○ Single
- ○ Married
- ○ Divorced
- ○ Separated
- ○ Widowed
- ○ Civil Union

Alcohol

- ○ None
- ○ Daily
- ○ Weekly
- ○ Occasionally

Caffeine

- ○ None
- ○ Daily
- ○ Weekly
- ○ Occasionally

Tobacco

Smoking Status

- ○ Current every day smoker
- ○ Current some day smoker
- ○ Former smoker
- ○ Never smoker
- ○ Smoker, current status unknown
- ○ Light tobacco smoker
- ○ Heavy tobacco smoker
- ○ Unknown if ever smoked
- ○ Cigarettes
- ○ Chewing Tobacco

Exercise

- ○ None
- ○ Yes

Drug Use

- ○ None
- ○ Yes

Family Medical History

- ○ No knowledge of family history

No family history of

- ○ Colon cancer
- ○ Crohn's Disease
- ○ Colon Polyps
- ○ Ulcerative Colitis

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
allergies	○	○
hay fever	○	○
frequent colds or bronchitis	○	○
exposure to HIV (AIDS)	○	○
hives	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
shortness of breath when lying flat	○	○
palpitations (irregular heart beats)	○	○
swelling of legs, feet or ankles	○	○
rapid heart beat	○	○

Constitutional

None	Y	N
chills	○	○
fatigue	○	○
fever	○	○
weight change	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○

ENMT

None	Y	N
ear pain	○	○
loss of hearing	○	○
frequent nose bleeds	○	○
nasal congestion or obstruction	○	○
frequent discharge (runny nose)	○	○
bleeding gums	○	○

Endocrine

None	Y	N
hair loss	○	○
heat or cold intolerance	○	○
excessive thirst	○	○
excessive hunger	○	○
excessive sweating (sweats)	○	○

Eyes

None	Y	N
blurred vision	○	○
eye pain	○	○
pain when looking at light	○	○
redness	○	○
dryness	○	○
double vision	○	○
loss of vision	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
constipation	○	○
diarrhea	○	○
difficult or painful swallowing	○	○
heartburn	○	○
vomiting blood	○	○
rectal bleeding	○	○
bloody stools	○	○
abdominal swelling	○	○
change in bowel habits	○	○
gas	○	○
jaundice	○	○
nausea	○	○
stomach cramps	○	○
difficulty swallowing	○	○

Genitourinary

None	Y	N
pain or burning on urination	○	○
genital lesions	○	○
blood in urine	○	○
frequent urination	○	○
urinary incontinence	○	○
change in urine stream	○	○
painful intercourse	○	○
excessive menstrual bleeding	○	○

Hematologic/Lymphatic

None	Y	N
easy bruising	○	○
bleeding tendencies	○	○
past blood transfusion	○	○
enlarged or swollen lymph nodes	○	○
bleeding gums or palpable lymph nodes	○	○

Integumentary

None	Y	N
abnormal looking moles	○	○
extremely dry skin	○	○
jaundice (yellow or orange skin)	○	○
itching	○	○
rashes	○	○
abnormal lumps or bumps	○	○
allergies	○	○
dryness	○	○
hives	○	○
lesions	○	○

Musculoskeletal

None	Y	N
joint pain	○	○
back pain	○	○
joint stiffness	○	○
muscle pain	○	○
muscle cramps	○	○

Neurological

None	Y	N
unsteady walking or standing	○	○
dizziness	○	○
fainting or blackouts	○	○
headaches	○	○
memory loss	○	○
numbness or tingling sensations	○	○
tremors or uncontrollable shaking	○	○

Psychiatric

None	Y	N
anxiety	○	○
nervousness	○	○
depression	○	○
personality or behavior changes	○	○
sleep disturbances	○	○
mood swings	○	○
panic attacks	○	○

Respiratory

None	Y	N
chronic cough	○	○
shortness of breath	○	○
coughing up blood	○	○
asthma	○	○
dyspnea	○	○
excessive sputum	○	○
wheezing	○	○

Pharmacy

Signature

Date

Risk Assessment for Hereditary Cancers

Patient Name: _____ Insurance Provider: _____
Date of Birth: _____ Todays Date: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY – BOTH MOM AND DADS SIDE OF FAMILY . Include any of below family members

Yourself Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather First Cousin

This is to determine if you are at risk of a gene mutation that may cause cancer in you or family members.

		YOU	Family Member	Moms side Or Dads side	Age at diagnosis
Y N	Breast Cancer	____	_____	_____	_____
		____	_____	_____	_____
		____	_____	_____	_____
Y N	Breast Cancer in both Breasts Or Breast cancer twice in same person	____	_____	_____	_____
Y N	Male Breast Cancer	____	_____	_____	_____
Y N	Triple Negative Breast Cancer Under 60 (ER-, PR-, HER2-)	____	_____	_____	_____
Y N	Pancreatic Cancer	____	_____	_____	_____
Y N	Ovarian Cancer	____	_____	_____	_____
Y N	Colon/Colorectal Cancer	____	_____	_____	_____
Y N	Uterine/Endometrial	____	_____	_____	_____
Y N	Stomach/Bladder	____	_____	_____	_____
Y N	Other Cancers (Renal pelvis, Brain, Biliary tract, Small bowel)	____	_____	_____	_____

Y N Ashkenazi Jewish ancestry

Y N Have you or any member of your family ever been tested for BRAC or Lynch Syndrome?

If yes, please explain: _____

_____
Patient's Signature Date

FOR OFFICE USE ONLY
- ☐ Candidate for further risk assessment and/or genetic testing
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled Date: _____

*For a better understanding of triple negative breast cancer please ask your healthcare provider.

- ☐ Patient offered genetic testing:
  - ☐ Accepted
  - ☐ Declined
- ☐ Patient not a candidate

_____
Healthcare Professional's Signature Date

BRAC Risk Factors

Personal History:

- Patient was personally affected with **Breast Cancer** at age **45** or younger or
- Patient was personally affected with **Ovarian Cancer** at **ANY AGE**

One Relative:

- One first or second degree relative with **Breast Cancer** at age **45** or younger or
- One first or second degree relative with **Ovarian Cancer** at **ANY AGE** or
- One first or second degree relative with **Bilateral Breast Cancer** when the first cancer dx was at age **50** or younger or
- One first or second degree **MALE** relative with Breast Cancer at **ANY AGE** or
- First or second degree relative with **Triple Negative** Breast Cancer at **60** or younger

Or Two Relatives:

- Two first or second degree relatives with Breast Cancer, one diagnosed at 50 or younger

Or Three Relatives:

- Three first or second degree relatives with Breast Cancer at **ANY AGE** or
- Three first, second or **THIRD** degree relatives with Breast Cancer, one diagnosed at 50 or younger or
- Combination of **Pancreatic and/or Prostate** (Gleason ≥7) **and/or Breast and/or Ovarian cancer** at **ANY AGE** in three first, second or **THIRD** degree relatives

Lynch Risk Factors

Personal History:

- Patient personally affected by **Colorectal or Endometrial Cancer** before age **50** or
- Patient was personally affected with **2 Lynch Syndrome Cancers** at **ANY AGE**; could be 2 separate colon cancer diagnoses (diagnosed at the same time or different times) or
- Patient has a Lynch Syndrome Cancer AND at least 1 first degree relative with a Lynch Syndrome Cancer, one of the cancers must be diagnosed **under age 50** or
- Patient has a Lynch Syndrome cancer at ANY AGE AND 2 or more first or second degree relatives with a Lynch Syndrome Cancer at ANY AGE or

Family History:

- At least 1 first or second degree relative with **Colorectal or Endometrial Cancer** diagnosed before age **50** or
- At least 1 first or second degree relative with 2 Lynch Syndrome Cancers at ANY AGE or
- At least 2 first or second degree relatives with Lynch Syndrome Cancers, one of them being in bold below (Main Lynch Cancers)

Lynch Syndrome Cancers: **Colorectal, Endometrial, Ovarian, Stomach**, Pancreatic, Small Intestine, Kidney (Renal Pelvis), Brain (Glioblastoma), Ureter, or Bile Duct

*****Relatives MUST BE ON SAME SIDE OF FAMILY*****

First Degree Relatives = Mom, Dad, Brother, Sister, Son, Daughter

Second Degree Relatives = Grandmother, Grandfather, Aunt, Uncle, Niece, Nephew, Granddaughter, Grandson

Third Degree Relatives = First Cousin, Great Aunt, Great Uncle, Great Grandmother, Great Grandfather

East Tennessee Gastroenterology PLLC

NOTICE OF PRIVACY POLICIES: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AN DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION.

PLEASE READ CAREFULLY: We at East Tennessee Gastroenterology, PLLC are committed to treating and using protected health information (PHI) responsibly. This notice describes the personal information we collect, how and when we use and disclose this information and your rights as they relate to your protected health information. Our entire staff has been trained and is committed to the protection of your information. This notice is effective June 1, 2010.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU: We may use and disclose personal, identifiable health information about you for a variety of purposes.

FOR TREATMENT: We may use health information about you in your treatment. For example, a nurse obtains treatment information about you and records it in a health record or during the course of your treatment; the treating provider determines he/she will need to consult another specialists in the area. He/she will share the information with such specialist and obtain his/her input.

FOR PAYMENT: We may use and disclose health information about you to bill for our services and collect payment from you or your insurance company. For example, we submit requests for payment to your health insurance company and provide information about you and the care given.

FOR HEALTH CARE OPERATIONS: We may use and disclose information about you for the general operation of our business. For example, we may obtain services from business associates who are not our employees but help us to operate more efficiently. We may disclose health information to those associates as necessary to perform the services for which we hire them. These business associates must promise, in writing, that they will respect the confidentiality of your information.

PUBLIC POLICY USES AND DISCLOSURES: We may disclose information about you to public health authorities charged with preventing or controlling disease, injury or disability. Also, we may disclose information regarding adverse events and product defects.

We may disclose information for law enforcement purposes as required by law or in response to a warrant or subpoena. If you are a member of the Armed Forces, we may release information deemed necessary to military authorities. We may release information to the correctional facility of an incarcerated patient when it is necessary for his/her treatment.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION: We are required to obtain a written authorization from you for any disclosures other than those described above. You may revoke that permission, in writing, at any time. If you do, we will no longer use or disclose personal information about you as covered by your authorization.

PATIENT RIGHTS: Although your health record is the physical property of East Tennessee Gastroenterology, PLLC, the information belongs to you.

YOU HAVE THE RIGHT TO: Request restrictions on the ways we use and disclose your information for treatment, payment and health care operations (we will consider your requests but we are not required to accept it).

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Inspect and copy medical, billing and other records use to make decisions about you. If you ask for copies, we may charge a fee for copying and/or mailing.

Request a correction of information you believe is incorrect or incomplete. We may deny your request if the information is accurate and complete.

To exercise any of your rights or to obtain more information concerning this notice, please contact, in writing, East Tennessee Gastroenterology, PLLC. 2404 Chambliss Ave, Cleveland, TN 37311. When making a request for a correction to your record, you must state a specific reason for making the request.

CHANGES TO THIS NOTICE: We reserve the right to make changes to this notice at any time. You may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS: If you have any complaints concerning our privacy practice, you may contact: Secretary of the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 202014.

You may contact us at: East Tennessee Gastroenterology, PLLC, ATTN: Kathy Ownbey, 2404 Chambliss Ave, Cleveland, TN 37311. Our phone is 423—339-2000

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED FOR FILING A COMPLAINT.

Colonoscopy: What you need to know

The Affordable Care Act, passed in March 2010, allows for certain preventative services, such as colonoscopies, to be covered at no cost to the patient. **However, there are strict guidelines that address circumstances under which a colonoscopy is considered preventative.** This means that sometimes a procedure will be viewed by an insurance carrier as diagnostic when a patient is under the impression that it was preventative (screening).

You might be entitled to a different level of benefits under your insurance policy for diagnostic services than for preventative services. Some insurance carriers require patients with gastrointestinal histories to meet a deductible and / or make a copayment.

We encourage you to contact your insurance carrier prior to your procedure. To help you understand which type of colonoscopy best describe your procedure, please review the information below.

Colonoscopy Categories: Diagnostic/Therapeutic Colonoscopy: Patient has past and/or present gastrointestinal symptoms, polyps, GI disease, iron deficiency anemia and/or any other abnormal tests.

Surveillance/High Risk Screening Colonoscopy: Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of GI disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (every 2-5 years, for instance).

Preventative Colonoscopy with Screening Diagnosis: Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of GI disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years).

Your primary care physician may refer you to our practice for a "screening" colonoscopy, but you might not qualify for the "screening" category. This is determined by the physician prior to your procedure. The determination is based upon past medical history, current symptoms, and/or information obtained from a referring physician. *Before the procedure, you should know your colonoscopy category.* After establishing the type of procedure that you are having, you can contact your insurance carrier to determine if your procedure will be covered and what your out-of-pocket expense will be. It is important to be specific in an inquiry to your insurance carrier. The diagnosis code and procedure code can be obtained from the physician's medical assistant if necessary. Also, be sure to indicate whether the procedure will be performed in the office, at East Tennessee Gastroenterology, or as an outpatient at Tennova Healthcare Cleveland.

Can the physician change, add or delete my diagnosis so that I can be considered eligible for colon screening?

No. The patient encounter is documented in your medical record from information you have provided as well as what is obtained during our pre-procedure history and assessment. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

Patients need to understand that strict government and insurance company documentation and coding guidelines prevent a physician from altering a chart or bill for the sole purpose of coverage determination. ***This is considered insurance fraud and punishable by law.***

What if my insurance company tells me that the doctor can change, add or delete a CPT or diagnosis code?

Unfortunately this is a common occurrence. Often member service representatives will tell a patient that if only the physician coded it with a "screening" diagnosis it would have been covered at 100%. Further questioning of the representative will reveal that the "screening" diagnosis can only be amended if it applies to the patient. Many insurance carriers only consider a patient over the age of 50 with no personal or family history as well as no past or present gastrointestinal symptoms as a "screening".

If you are given this information, please document the date, name, and phone number of the insurance representative. Next, contact our billing department at (423) 339-2000. An audit will be performed to review the billing and investigate the information given. Often the outcome results in the insurance company calling the patient back to explain that an insurance carrier should not ever suggest a physician change their billing to produce better benefit coverage. The billing of a procedure should not be changed unless the changes more accurately describe the reason for service and exactly which services were performed.

****If you have any questions or concerns regarding your insurance benefits and coverage, please contact your insurance carrier.***

****Our business office staff can be reached at (423) 339-2000. We are happy to assist in reviewing coverage and benefit information provided by your insurance carrier.***

Thank you for your cooperation