East Tennessee Gastroenterology

Patient Registration

Thank you for choosing our office! To serve you properly, we need the following information completed below. Please print. All information will be confidential.

Patient Demographics

Legal First Name | Middle | Last Name | Suffix | Preferred First Name

Address | Apt# | City | State | Zip Code

Primary Phone Number | Secondary Number

Date of Birth | Social Security Number | Marital Status | Gender

Email address

Pharmacy Name | Pharmacy Address | Pharmacy Phone Number

Primary Care Physician

Emergency Contact Name | Relationship | Phone number

Primary Insurance	Subscribers Name	Social Security Number	Date of Birth

Secondary Insurance	Subscribers Name	Social Security Number	Date of Birth

Privacy Options: In some cases, we are unable to reach our patients during working hours. Your responses below will give us guidance when we cannot contact you personally.

May we leave a message regarding results, appointments, balances, insurance information, etc. on the phone numbers provided. ____**Yes** ____**No**

Consent for Release of Medical Information: I, _____, grant permission for the person(s) listed below to have access to all my medical information that pertains to my care from the physician(s) of this group. This includes, but is not limited to, appointment times, lab results, my physician(s) plan for health care, etc.

Patient Signature/Date: _____

(Please list below the names and relationship of people we may speak with on your behalf)

1. _____
2. _____
3. _____

Consent to Import Medications 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 Preferences: I would like to receive preventative care and follow-up care reminders. ___**Yes** ___**No**

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 (TPO). For more details about these uses and disclosures, please see our privacy notice.

We reserve the right to change our privacy policies as described in the privacy notice. You may call us or request an updated copy.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out TPO. 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.

Your signature below indicates that you have received the "Notice of Privacy Policy" for East Tennessee Gastroenterology.

Patient/Responsible Party **Date**

I authorize East Tennessee Gastroenterology, PLLC, to release to my insurance company, managed care organizations I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges, and any and all balances not covered under a contractual write-off agreement between East Tennessee Gastroenterology, PLLC and my third-party payer. My carrier's failure to pay does not release me from this responsibility, I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs. I authorize East Tennessee Gastroenterology, PLLC to release to my insurance company, managed care

organization, state agency(ies), federal agency(ies), Health Care Financing Administration, Third Party Administrators, and/or Worker's compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize East Tennessee Gastroenterology, PLLC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, Medigap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial Workers Compensation, Liability, and/or any other insurance benefits be made on my behalf to East Tennessee Gastroenterology, PLLC for services furnished to me or on my behalf of that provider. I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges, and any and all balances not covered under a contractual write-off agreement between East Tennessee Gastroenterology, PLLC and my third-party payer. My carrier's failure to pay does not release me from this responsibility, I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

Patient/Responsible Party Signature **Date**

East Tennessee Gastroenterology

2404 Chambliss Ave.
Cleveland, TN 37311
(423) 339-2000

No-Show/Missed Appointment/Procedure Policy

Procedures

No shows and missed procedures affect our office and staff in numerous ways. We reserve the time and resources to perform your procedure(s).
If you are scheduled for a screening procedure, which is almost always covered by insurance, we will submit the bill to insurance. **However, if there is a no- show, we do reserve the right to bill you $100.00.**

If you are scheduled for a diagnostic procedure at our office the following applies:

EGD only: $200.00 is required prior to your service date, if you have Commercial Insurance.

Diagnostic EGD/Colonoscopy: $300.00 payment is required prior to your service date, if you have Commercial Insurance.

Medicare / Medicare Advantage Plans or Medicare with a Supplement Plan: We will not collect any money upfront.

We will still submit your diagnostic services to your insurance company and if you are owed a refund, a refund or credit will be issued. If there are additional amounts owed due to deductible/co-insurance, we expect that payment will be made within 90 days or a payment plan is established.

Office Visits

Our office policy for no-show office visits remains that we will reserve the right to charge a $50.00 fee for missed appointments if you have not provided notice of cancellation 24 hours before your scheduled appointment. A no-show fee must be paid prior to your next appointment. If there are multiple no-shows and/or you are at risk by not having a procedure or follow-up, it will be our doctor's discretion to dismiss a patient from our care.
I have read and understand the No Show/Missed Appointment/Procedure Policy and understand my responsibility to plan appointments/procedures accordingly. Please call 423-339-2000 to cancel the appointment and to notify us as soon as possible if you will be late for an office visit.

Patient 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
- ☐ Middle Eastern or North African (MENA)
- ☐ Other Race
- ☐ 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
- ☐ Unknown

Sex

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Unknown

Allergies

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

Other: _____

Current Medications

- ☐ None

Name	Dose	How taken?

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
- ☐ Smokeless
- ☐ Other

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
Personal history of colon cancer	○	○	○	○	○	○
Personal history of colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Ulcerative colitis, unspecified	○	○	○	○	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

☐ Yes ☐ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

☐ Yes ☐ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

☐ Yes ☐ No

Signature

Signature Date

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present