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 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?

Immunizations

- ☐ None
- ☐ Hep A, adult — When: _____
- ☐ Hep B, adult — When: _____
- ☐ Pneumonia (YYYY) — When: _____
- ☐ Influenza (MM/DD/YYYY) — When: _____
- ☐ Influenza, seasonal, injectable — 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	☐ Diverticulitis	☐ Ulcerative colitis	☐ Crohns
	☐ Colon Cancer			
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	☐ Alzheimer
	☐ Dementia	Other: _____	Other: _____	Other: _____
	Other: _____	Other: _____		

Previous Procedures

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

Review Of Systems

Allergic/Immunologic

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

Cardiovascular

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

Constitutional

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

ENMT

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

Endocrine

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

Eyes

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

Gastrointestinal

	Y	N
None		
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

	Y	N
None		
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

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

Integumentary

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

Musculoskeletal

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

Neurological

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

Psychiatric

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

Respiratory

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

Pharmacy

Name _____ Address _____ Phone _____

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

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

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: $300.00 is required before your service date

Diagnostic EGD/Colonoscopy: $500.00 payment is required before your service date

We will still submit your diagnostic services to your insurance company, and if you are owed a refund, one will be issued. If additional amounts are owed due to deductible/co-insurance, we expect payment to be made within 90 days, or a payment plan 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 before 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 timely and to notify us as soon as possible if you will be late to an office visit.

Patient Signature: _____ Date: _____