Gastroenterology Associates

135 West Ravine Rd, Suite 3A ♦ Kingsport, Tennessee 37660 Telephone: 423-246-6777 ♦ Fax: 423-245-5439

Patient Name: _____

Your appointment is scheduled with:

3rd Floor
- ☐ Douglas E. Homoky, M.D.
- ☐ Rathi Narayan, M.D.
- ☐ Christopher Mathews, M.D.
- ☐ Erika Grigg, M.D.
- ☐ Mitzi Musick, NP
- ☐ Carol Sanders, NP

4th Floor
- ☐ Douglas J. Springer, M.D.
- ☐ R. Douglas Strickland, M.D.
- ☐ Mitzi Musick, NP
- ☐ Carol Sanders, NP

Your appointment has been made for _____ at _____ please arrive at _____

Please complete the registration forms attached prior to your visit and return to us in the enclosed envelope.

PLEASE READ THE FOLLOWING

OFFICE HOURS: Office hours are Monday – Friday from 8:00 a.m. to 5:00 p.m. We are closed on major holidays.

INSURANCE CARDS: Please bring your insurance card (s) to each appointment.

COPAYS/BALANCES: You are expected to pay your co pay on the day of your visit. We will file your insurance and any remaining balance will billed to your account. You are responsible for knowing your insurance benefits.

REFERRALS: If your insurance coverage requires a referral to see a specialist, please have your primary care physician fax a written referral to 423-245-5439. Without the required referral you will be financially responsible for medical services rendered.

SELF-PAY PATIENTS: Self-pay patients will be required to pay $150.00 the first visit and $75.00 for each subsequent visit. The remaining balance will be billed to your account and payment is due when you receive your statement. A payment agreement will be signed during the first visit.

NO SHOW POLICY: It is the policy of Gastroenterology Associates that after two no-shows for new patients and three no-shows for established patients, you may be dismissed from our office. There is a $30.00 fee for missed, cancelled or rescheduled appointments without at least 24hrs prior notice.

PRESCRIPTION REFILLS: Please allow 48 hours on prescription refills. Requests for medication refills should be made during regular office hours and not at times when the office is closed.

NARCOTIC PAIN MEDICATION: OUR PRACTICE DOES NOT OFFER CHRONIC PAIN MANAGEMENT SERVICES and, in general, our physicians do not prescribe narcotic pain medications. It is our expectation that any chronic pain management needs be handled by your primary care physician or pain management specialist.

RETURN PHONE CALLS: Except for an emergency, please allow 48 hours for clinical staff to return calls. This will allow time for the physician to review and respond to the nurse regarding your concern.

X-RAYS/LABS/PROCEDURES: Please allow up to 10 days for the nurse to call regarding any x-rays studies, lab results and procedures pathologies. This will allow for the test to be processed and reviewed by the physician.
If you have not heard from your physician's nurse at the end of 10 days feel free to call our office at 423-246-6777.

NO SHOW/CANCELLATION/RESCHEDULE POLICY

We understand that scheduling conflicts occur from time to time however, we request at least 24 hours advance notice if you are unable to keep your scheduled appointment. There will be a $30.00 charge for missing a scheduled appointment, or for cancelling or rescheduling without a 24 hour notice. Three no-shows, cancellations, and/or reschedules may result in your dismissal from all Gastroenterology Associates providers.

This policy has been developed in an effort to better serve our patients by providing same day appointments for those who are sick and need to be seen. If someone schedules an appointment and then does not show, cancels, or reschedules we have lost an available appointment that could have been used for a sick patient.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no shows, cancellations and reschedules.

Patient Signature_____

Date_____

Effective 4/22/13

GASTROENTEROLOGY ASSOCIATES
KINGSPORT ENDOSCOPY CORPORATION
THE ENDOSCOPY CENTER OF BRISTOL, LLC

Patient Information

DATE: _____ ACCOUNT NO. _____ DATE OF BIRTH _____

Patient's Last Name First MI Home Phone Work/Business Number

_____

Address City County State Zip Code Cell Phone Number

_____

Social Security Number Sex (Check One)

_____Male ____ Female ____ ____ Married ____ Single ____ Divorced ____ Widowed

Employer Name Employer Address Employer Phone Number

_____

Spouse's Name Spouse's Employer Spouse Employer's Phone

_____

Spouse's Date of Birth Spouse's Social Security #

_____

E-Mail Address Race: African American Asian Caucasian Native American Other

_____

PERSON RESPONSIBLE FOR ACCOUNT

Last Name First MI Relationship to Patient

_____

Address City State Zip Code

_____

Social Security Number Home Phone Work/Business Phone Birth Date

_____

Employer Name Employer Address

_____

Employer Phone Number Contact Person

_____

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**	**THIRD INSURANCE**
Subscriber Date of Birth	Subscriber Date of Birth	Subscriber Date of Birth
Subscriber Social Security #	Subscriber Social Security #	Subscriber Social Security #
Subscriber Employer	Subscriber Employer	Subscriber Employer
Patient's Relationship to Subscriber	Patient's Relationship to Subscriber	Patient's Relationship to Subscriber

****We will copy your insurance cards at each visit.****

IN CASE OF EMERGENCY CONTACT (*OTHER THAN PATIENT'S HOME NUMBER*)

Name Home Number Work or Business Number Relationship to Patient

_____

Do you have a living will? ___ YES ___ NO. If so, please bring a copy with you to your next visit. Are you an organ donor? ___ YES ___ NO

Referring Physician: _____ If not referred by Physician, how did you hear about us?

Family Physician: _____ Pharmacy Name/Phone _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

HIPAA Privacy Acknowledgement

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? _____ YES _____ NO. If **NO**, is there another number we may use to reach you?
   Area Code: _____ Phone Number: _____
   May we call you at work? _____ YES Work Phone Number: _____
   _____ NO
2. May we mail information to your home address regarding your appointments or test results? ____ YES ____ NO
   If **NO**, is there another address to which we may send your information? Please provide that mailing address:
   _____
3. Please list a family member(s) with whom we may release your medical information if needed:

   NAME **AREA CODE AND PHONE NUMBER** **RELATIONSHIP**

   _____
   _____
   _____

   Please note that we can only release your medical information to the person(s) listed above.
4. I have received a copy of the Physician's Practice "Notice of Privacy Practices for Protected Health Information".

_____ _____
Signature Date

INSURANCE INFORMATION AND CONSENT FOR TREATMENT

Patient and/or guarantor is responsible for charges incurred. You are responsible on the day of your visit for your co-pay and/or percentage, for which your insurance company is not liable. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor, we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I have read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information required in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____
Signature Date

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for services furnished me by that provider. I authorize any holder of medical information about me to release to my Medigap Insurer any information needed to determine these benefits payable for released services.

_____ _____
Signature Date

MEDICARE "B" SIGNATURE AUTHORIZATION

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 or it's intermediaries or carriers, or to the billing agent of this physician or supplier, 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 the party who accepts assignment.

I understand that this is a lifetime authorization.

_____ _____
Signature Date

Gastroenterology Associates
WWW.GASTROTN.COM

135 W. Ravine Road, Suite 3A; Kingsport, TN 37660 - Phone (423) 246-6777 Fax (423) 246-7766, or (423) 245-7191

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____
MRN: _____ Date of Birth: _____
Age: _____ Notes: _____

Race:

□ White/Caucasian □ Black or African American □ Asian □ American Indian or Alaska Native
□ Native Hawaiian Or Other Pacific Islander □ Mixed □ Other □ Unknown □ Patient declines to provide information

Ethnicity:

□ Hispanic or Latino □ Not Hispanic or Latino □ Patient declines to provide information

Gender:

□ Male □ Female □ Other

Preferred Language:

Other: _____

Contact Preference:

Other: _____

Allergies:

□ Patient has no known allergies □ Patient has no known drug allergies

□ Aspirin	□ Codeine	□ Demerol	□ Iodine	□ Latex
□ Morphine	□ Novocain	□ Penicillins	□ Propofol	□ Sulfa
□ Surgical Tape	□ Versed	□ Tape	□ Penicillin	Other: _____

Immunizations:

□ None

□ Flu vaccine	□ Hep B	□ Hep A	□ Pneumonia	□Varivax
When _____	When _____	When _____	When _____	When _____

Diagnostic Studies/Tests:

□ None

□ Lab Work	□ X-Rays	□ Other	□ Other	□ Other
When _____	When _____	When _____	When _____	When _____

Past or Present Medical Conditions:

□ None

GI Related	□ Anemia	□ Cirrhosis of Liver	□ Colitis	□ Colon Cancer
	□ Colon Polyps	□ Crohn's Disease	□ Diarrhea	□ Diverticulitis
	□ Diverticulosis	□ Fatty Liver	□ Gallstones	□ Hepatitis A
	□ Hepatitis B	□ Hepatitis C	□ Hiatal Hernia	□ Irritable Bowel Syndrome
	□ Lactose Intolerance	□ Pancreatitis	□ Reflux	□ Stomach Ulcer
	□ Ulcerative Colitis	□ Other: _____	□ Other _____	
General	□ Asthma	□ Atrial Fibrilation	□ Back Pain (Chronic)	□ Breast Cancer
	□ Cancer	□ Chronic Lung Disease	□ Congestive Heart Failure	□ Depression
	□ Diabetes Mellitus	□ Emphysema	□ Frequent Urinary Tract Infection	□ Glaucoma
	□ Gout	□ Heart Attack	□ Heart Murmur	□ High Blood Pressure
	□ High Cholesterol	□ High Triglycerides	□ History of Suicide Attempts	□ HIV/AIDS
	□ Irregular Heart Beat	□ Kidney Disease	□ Kidney Failure	□ Kidney Stone
	□ Lupus	□ Migraines	□ Osteoarthritis	□ Paralysis
	□ Parkinson's Disease	□ Phlebitis	□ Pneumonia	□ Rheumatic Fever
	□ Rheumatoid Arthritis	□ Seizures	□ Skin Cancer	□ Sleep Apnea
	□ Stroke	□ Tuberculosis	□ TB Skin Test Positive	□ Uterine Cancer
Other	□ Thyroid Disease			

Previous Procedures:

□ None

□ Appendix	□ Breast	□ Cardiac Surgery	□ Colonoscopy	□ C-Section
□ EGD	□ ERCP	□ Gallbladder	□ Heart By-Pass	□ Heart Stent
□ Heart Valve Replacement	□ Hemorrhoids	□ Hiatal Hernia	□ Hysterectomy Partial	□ Hysterectomy Total

□ Joint Surgery/Replacement □ Kidney □ Obesity Surgery □ Prostate

□ Stomach □ Thyroid □ Tonsils □ Transplant Surgery □ Tubal Ligation

□ Vasectomy □ Sigmoidoscopy □ Cyst on Ovary Other:_____

Social History:

Occupation: _____ Number of Children: _____

Marital Status

□ Single □ Married □ Divorced □ Separated □ Widowed
□ Civil Union □ Unknown □ Other _____

Alcohol

□ None

Type	Quantity	Number	Frequency
□ Beer	_____	_____	Times/Week _____
□ Wine	_____	_____	Times/Day _____
□ Liquor	_____	_____	Times/Week _____
□ Quit Using	_____	_____	

Caffeine

□ None

Tobacco

Smoking Status □ Current everyday smoker □ Current some day smoker □ Former smoker □ Never smoker
□ Smoker, current status unknown □ Light tobacco smoker □ Heavy tobacco smoker □ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
□ Cigarettes	_____	_____	_____Packs/Day	_____
□ Cigars	_____	_____	_____Times/Week	_____
□ Smokeless	_____	_____	_____Times/Week	_____

Drug Use

□ None

Type	Quantity	Number	Frequency
□ Illicit Drugs	_____	_____	_____
□ Injection Drug Use	_____	_____	_____

Exercise

□ None

Type	Quantity	Number	Frequency
□ Aerobics	_____	_____	_____
□ Bike	_____	_____	_____

□ Golf	_____	_____	_____
□ Jog	_____	_____	_____
□ Lift Weights	_____	_____	_____
□ Swim	_____	_____	_____
□ Walk	_____	_____	_____

Family Medical History:

□ No knowledge of family history

No family history of: □ colon cancer □ polyps □ Crohn's disease (disorder) □ Ulcerative colitis (disorder)

Health Status

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Age/Date of Birth										
Healthy	□	□	□	□	□	□	□	□	□	□
Ill	□	□	□	□	□	□	□	□	□	□
Seriously Ill	□	□	□	□	□	□	□	□	□	□
Disabled	□	□	□	□	□	□	□	□	□	□
In Remission	□	□	□	□	□	□	□	□	□	□
Alive	□	□	□	□	□	□	□	□	□	□
Deceased/at Age	□	□	□	□	□	□	□	□	□	□
	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Cause of Death _____

Diagnoses

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Colitis	□	□	□	□	□	□	□	□	□	□
Family HX of Colon CA	□	□	□	□	□	□	□	□	□	□
Family HX of Colon Polyps	□	□	□	□	□	□	□	□	□	□
Crohn's Disease (Colon)	□	□	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□	□	□
Esophageal Cancer	□	□	□	□	□	□	□	□	□	□
Gall Bladder Disease	□	□	□	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□	□	□	□
Liver Cancer	□	□	□	□	□	□	□	□	□	□
Liver Disease	□	□	□	□	□	□	□	□	□	□
Pancreas Cancer	□	□	□	□	□	□	□	□	□	□
Stomach Cancer	□	□	□	□	□	□	□	□	□	□
Ulcer Disease	□	□	□	□	□	□	□	□	□	□
Ulcerative Colitis	□	□	□	□	□	□	□	□	□	□
Colon Cancer	□	□	□	□	□	□	□	□	□	□

Medication List

Please complete the information below & return with the health history in the envelope provided.

Today's Date: ______________________________ Acct. No. ____________________

Name: ______________________________________ Date of Birth: ________________

List all medications that you currently take, including vitamins, over-the-counter medications and herbal preparations.

Medication Name (Please Print Clearly)	Dosage (mg)	Frequency (How often per day)	Check if need refill

Gastroenterology Associates
Kingsport Endoscopy Corporation
The Endoscopy Center of Bristol, LLC

Notice of Privacy Practices For Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

Please review this document carefully!

Understanding Your Health Record Information

Your physician is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Before we can use the information for these purposes, we must obtain your writer consent. Your consent is included on a form that you have been asked to sign.

This Notice gives examples of how we will use or disclose your health information for treatment, payment, and health care operations. The Notice describes circumstances when we may have to use or disclose the information even without your consent.

Examples of Uses of Your Health Information for Treatment, Payment, and Health Care Operation Purposes are:

Treatment: We will use and disclose your health information to provide you with medical treatment or services. Nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we submit requests for payment to your health insurance company. The health insurance company or business associate helping us obtain payment may request information from us regarding your medical care. We will provide information to them about the care you were given.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records. We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, credentialing, medical record review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

Special Uses

We may also use your information to contact you with appointment reminders and information about treatment alternatives or other health-related services that may be of interest to you.

Other Uses and Disclosures

We may use and disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted by law to give out health information without your consent for the following purposes:

- **Required by Law:** We may be required by law to report suspected abuse or neglect, gunshot wounds, or similar injuries and events.
- **Health Oversight:** We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- **Public Health Activities:** As required by law, we may disclose vital statistics, diseases, and information related to recalls of dangerous products to public health authorities.
- **Law Enforcement Purposes:** Subject to certain restrictions, we may disclose information require by law enforcement officials.
- **Judicial and Administrative Proceedings:** We may disclose information in response to an appropriate subpoena or court order.
- **Serious Threat to Health or Safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Deaths:** We may report information regarding deaths to coroners, medical examiners, and funeral directors.
- **Military and Veterans:** If you are a member of the armed forces we may release information as required by military command authorities.

- **Workers Compensation:** WE may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
- **Research:** We may use or disclose information for approved medical research or clinical trials.

In all other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Your Health Information Rights

Although your health records are the physical property of this practice, you have the following rights with regard to the information contained therein:

- **Request Restrictions:** You may request restrictions on certain uses and disclosures of your health information. We are not required to grant the request, but we will comply with any request granted. We **must,** however, comply if you request that we restrict disclosures to your insurance company but only if you have paid your services in full out of your own pocket.
- **Confidential Communications:** You may ask us to communicate with you confidentially by requesting that communication of your health information be made by alternative means or at an alternative location be delivering the request in writing to our office using the form we give you upon request. If we have your health information in an electronic format, you have the right to request it in that format in addition to a paper copy.
- **Inspect and Obtain Copies:** You have the right to view or receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our offices using the form we provide to you upon request. An accounting will not include uses of the information for treatment, payment, or operations, disclosures. There may be a small charge for the copies.
- **Paper Copy of NPP:** You have the right to request a paper copy of this Notice of Privacy Practices even if you have already received it in an electronic format.
- **Amended Information:** If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that your health care record be amended by delivering a written request to our office using the form we provide to you upon request (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information. If you want to exercise any of the above rights, please contact our Privacy Officer at the number listed, in person, or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights. Please contact the number listed below to obtain the appropriate form for exercising these rights.

Our Legal Responsibilities

This office is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this notice
- Notify you if we cannot accommodate a requested restriction or request,
- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

Changes in Privacy Practices

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy. For more information about our privacy practices, contact the number listed below.

Complaints

If you are concerned that we have violated your privacy rights, of if you disagree with a decision we made about your records, you may contact our office at the number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The proper person at the number listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Effective Date: August 26, 2013

If you have questions, requests, or complaints, please contact our offices at (423) 246-6777- Kingsport, (423) 274-6350-Bristol

Gastroenterology Associates

Holston Valley Physicians Building, Suite 3A
135 W. Ravine Rd., Kingsport, TN 37660
(423) 246-6777

235 Medical Park Blvd.
Bristol, TN 37620
(423) 274-6350

616 Campus Drive
Abingdon, VA 24210
(423) 274-6350

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