PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Patient Social Security Number:_____ - _____ - _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc ☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

PHYSICIANS

Referring Physician: _____ **Primary Care Physician**: _____

PHARMACY

Pharmacy Name:_____Pharmacy Phone Number: _____

Pharmacy Address: _____

CONSENT TO LEAVE A VOICEMAIL

_____: (Initial**) I CONSENT** to staff leaving voicemails. This information may include, but is not limited to, demographic information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, medications, diagnosis, test results, etc.)

_____: (Initial) **I DECLINE** to staff leaving voicemails

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date**:** _____

Printed name of patient or personal representative:_____Relationship to patient: _____

GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE
Patient Consent for Financial Communications

Patient Name: _____
DOB: _____

Financial Agreement

- I acknowledge, that as a courtesy, GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE any insurance or other third-party benefits available for health care services provided to me. I understand GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

Patient History

Page 1

Name_____ Date of Birth_____ Date_____

Name of physician who referred you_____

Primary Care Physician_____

Please list all of your current physicians and their specialties_____

Main Reason for today's visit?_____

Do you currently have, or have you had in the past, any medical problems?

◯ Alcoholism	◯ Diabetes	◯ Seizures	◯ Hepatitis	◯ Anemia
◯ Drug Abuse	◯ Sleep Apnea	◯ HIV/AIDS	◯ Anorexia/Bulimia	◯ Emphysema
◯ Stroke	◯ H. pylori	◯ Asthma	◯ Heart Disease	◯ Thyroid Disease
◯ Irritable bowel Syndrome	◯ Blood clot in legs/lungs	◯ Heart Failure	◯ Acid Reflux/heartburn	◯ Pancreatitis
◯ High blood pressure	◯ Colon polyps	◯ Ulcerative colitis	◯ High cholesterol	◯ Crohn's Disease
◯ Ulcers	◯ Depression/Anxiety	◯ Kidney Disease	◯ Diverticular Disease	
◯ Cancer (Type_____)				

Any other problems no listed above?_____

Have you undergone a colonoscopy? ◯ No ◯ Yes When?_____ Where?__

By Whom?_____

Have you undergone an upper endoscopy? ◯ No ◯ Yes When?_____ Where?__

By Whom?_____

Have you ever had surgery?

◯ Appendix	◯ Heart Bypass	◯ Hysterectomy	◯ Pacemaker	◯ Colon Surgery
◯ Heart stent	◯ Kidney surgery	◯ Splenectomy	◯ Gallbladder	◯ Heart valve
◯ Lap band	◯ Stomach surgery	◯ Gastric bypass	◯ Hernia	◯ Mastectomy
◯ Tubal ligation				

Any other surgeries not listed above?_____

Are you taking any blood thinners? ◯ No ◯ Yes – Please list medication and name of physician who prescribes it

_____

Please list all other medications (including over-the-counter medications/supplements) ◯ See Attached List

_____

_____

_____

Are you allergic to, or have you had a bad reaction to any medications? ◯ No ◯ Yes – Please list

_____

When did you last have?

Blood Test_____ Upper GI x-ray_____ Barium enema_____

Abdominal Ultrasound_____ Abdominal CT Scan_____

Patient History

Social History

◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated ◯ Partner

Occupation:_____ ◯ Retired ◯

Disabled

Tobacco: ◯ Smoke ◯ Chew ◯ Dip ◯ No ◯ Yes – How much?_____

Alcohol: Drink ◯ Beer ◯ Wine ◯ Liquor? ◯ No ◯ Yes – How much?_____

Do you use or have you in the past used drugs? ◯ No ◯ Yes – Specify_____

o Currently? o In past?

Family History

Has any close family member had any of the following?

	Who?		Who?
◯ Colon Polyps	_____	◯ Crohn's Disease	_____
◯ Colon Cancer	_____	◯ Ulcerative Colitis	_____
◯ Esophageal Cancer	_____	◯ Gallbladder Disease	_____
◯ Pancreatic Cancer	_____	◯ Liver Disease	_____
◯ Stomach Cancer	_____	◯ Problems with anesthesia	_____
◯ Uterine Cancer	_____	◯ Problems with bleeding	_____
◯ Ovarian Cancer	_____	◯ Alcoholism	_____

Are you currently experiencing concerns with any of the following? (check any that apply)

◯ Abdominal pain	◯ Mouth sores	◯ Dizziness	◯ Nausea, vomiting	◯ Nosebleeds
◯ Headache	◯ Increased gas	◯ Hearing	◯ Weakness	◯ Swallowing
◯ Sore throat	◯ Anxiety	◯ Heartburn	◯ Sinuses	◯ Depression
◯ Reflux	◯ Leg swelling	◯ Stress	◯ Diarrhea	◯ Palpitations
◯ Constipation	◯ Chest pain	◯ Rectal Bleeding	◯ Wheezing	◯ Fecal Incontinence
◯ Shortness of breath	◯ Black stool	◯ Cough	◯ Greasy stool	◯ Urinary burning
◯ Jaundice	◯ Dark urine	◯ Fever	◯ Urine incontinence	◯ Intolerance to cold
◯ Intolerance to heat	◯ Enlarged lymph glands	◯ Milk Products	◯ Weight Gain	◯ Weight Loss
◯ Starting Stream	◯ Muscle pain	◯ Fatigue	◯ Joint pain	◯ Eye pain
◯ Skin rash	◯ Vision	◯ Easy Bruising	◯ Environmental allergies	

Women:

◯ Vaginal bleeding

Are you/could you be pregnant? ◯ No ◯ Yes

◯ Last Period_____ or ◯ Hysterectomy ◯

GASTROENTEROLOGY SPECIALISTS OF MIDDLE TENNESSEE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Date of Birth:	Last 4 digit SSN *(optional)*:
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name:	Recipient Address/City/State/Zip	Phone Number: ( ) Fax Number: ( )
PHI Sender Name:	Sender Address/City/State/Zip	Phone Number: ( ) Fax Number: (

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: Event:

Purpose of Disclosure: **Continuation of Care**

Is this request for psychotherapy notes?
Yes, then this is the only item you may request on this authorization.
No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
All PHI in record History and Physical Consult Report Operative Report Progress Notes		Physician Orders Laboratory Imaging/Radiology Nursing Notes Medication Record		Demographics Rehabilitation Services Special Test/Therapy Itemized Bill/Claims Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information._____(Initial). If not, applicable, check here

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: