Mid-Atlantic G.I. Consultants, PA.

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Diplomates of American Board of Internal Medicine

Diplomates of American Board of Gastroenterology

Dear Patient,

Mid-Atlantic G.I. Consultants would like to thank you for choosing our practice. In order to better meet the needs of our patients we created a system that allows patients to avoid unnecessary office consultations prior to procedures. However, if you prefer, you can always request an office visit prior to the procedure.

Listed below are simple steps to schedule your procedure.

1. Carefully read and complete the information enclosed.

1. Type and fill all the required information.
2. Print all the 13 pages to a printer.
3. Send by FAX or MAIL following documents to us.

    i. Copies of health insurance card (front and back)
    ii. Medical history, medical registration form (signed)
    iii. Financial policy, consent to release information (signed)
    iv. Medicare authorization (for applicable patients) (signed)

Our Scheduling department will contact and schedule you upon receipt of this information.

If there are any questions please call.
Tel: (302) 225-2380
Fax: (302) 225-2388

Mid-Atlantic GI Consultants, PA
537 Stanton Christiana Road. Suite 203,
Newark, DE 19713

Mid-Atlantic G.I. Consultants, P.A.

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PATIENT REGISTRATION FORM (Downloaded)

Please complete/ Update Form

Date _____ Are you? ☐ New Patient ☐ Existing Patient

If you are an existing patient, name of your GI doctor: _____.

Allergies: _____ Allergic/Sensitive to Latex? ☐ Yes ☐ No

Last Name: _____First Name: _____M.I._____

Birth date: _____Age:_____ SS#: _____

☐Male ☐ Female Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Tel: _____ Work Tel: _____ Mobile/Cell:_____

Email Address (if present):_____

Can we call you at work to schedule the procedure (if we can't reach you at home or Cell)
Yes ☐ No ☐ : _____

Spouse's Name: _____D.O.B: _____

In the event of an emergency, whom should we contact? Name: _____

Relationship: _____Emergency Contact No: _____

May we share your medical information with family member(s) or friend(s)?: Yes ☐ No ☐

If 'Yes', with whom? Name: _____ Relationship: _____

Telephone: _____

Reason for referral: Office Visit ☐, Colonoscopy ☐, Upper Endoscopy ☐

PCP doctor: _____Phone#: _____

Referring doc (if not PCP): _____ Phone#: _____

Pharmacy Name: _____ Phone#: _____

Your Employer: _____ Your Occupation: _____

Primary Insurance

Insurance Company: _____

Member ID#: _____

Group#: _____ Group#: _____

Co-pay/Deductible Amount: _____

Ins. Co. Address:

_____

Secondary Insurance

Insurance Company: _____

Member ID#: _____

Group#: _____ Group#: _____

Co-pay/Deductible Amount: _____

Ins. Co. Address:

_____

Please fill the information below if you are not the subscriber:

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Birth Date: _____

Subscriber SSN: _____

Subscriber Employer: _____

CONSENT FOR RELEASE OF INFORMATION, AUTHORIZATION, AND ASSIGNMENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I, _____CERTIFY THAT THE INFORMATION
I HAVE COMPLETED ON THIS REGISTRATION FORM IS CORRECT AND CURRENT TO THE BEST OF MY KNOWLEDGE.

I, _____, hereby authorize *Mid-Atlantic G.I. Consultants, P.A.* to use and/or disclose my heath information which specifically identifies me or which can reasonably be used to identify me to carry our treatment, payment, and health care operations Specifically, I authorize the release of my medical information to my insurance company or companies. I understand that while this consent is voluntary, if I refuse to sign this consent, the physicians of *Mid-Atlantic G.I.Consultants, P.A.* can refuse to treat me.

I have been informed that *Mid-Atlantic G.I. Consultants, P.A.* has prepared a "Notice of Privacy Policies" pamphlet which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I will be offered a copy of this pamphlet and will have the right to review it prior to signing this consent.

I understand that I may revoke this consent at any time by notifying *Mid-Atlantic G.I. Consultants, P.A.* IN WRITING, but if I revoke my consent, such revocation will not affect any actions that *Mid-Atlantic G.I.Consultants, P.A.* took before receiving my revocation.

I understand that *Mid-At/antic* G.I. *Consultants, P.A.* has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that *Mid-Atlantic GI. Consultants, P.A.* restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations, I understand that *Mid-Atlantic* G.I. *Consultants, P.A.* does not have to agree to such restrictions, but that once such restrictions are agreed to, *Mid-Atlantic G.I. Consultants, P.A.* must adhere to such restrictions.

I REQUEST THAT PAYMENTS ISSUED FROM MY INSURANCE COMPANY, OR COMPANIES, BE MADE TO: *Mid-Atlantic G.I. Consultants, P.A.*

_____

Signature of patient or patient's representative **Date**

_____ _____

Print name of patient or patient's representative **Relationship to patient**

Mid-Atlantic G.I. Consultants, P.A

537 Stanton Christiana Road. Suite 203, Newark, DE 19713 • (302) 225-2380 • Fax (302) 225-2388

MEDICAL HISTORY Date: _____

Please complete this history form. This will allow us to best serve your health needs. The information contained herein is strictly confidential and will not be released without your permission.

NAME (Last name, First Name, MI) : _____DOB: _____

Height:_____ Weight:_____

Reason for Referral: EGD ☐ Colonoscopy ☐ Office visit ☐ Other ☐ _____

Family Doctor's Name and Phone Number: _____

Cardiologist's Name and Phone Number: _____

FAMILY HISTORY (Fill that are applicable)

FAMILY	Sex		Age	Health Problems.
Father	**X**			
Mother	**X**			
Brothers/Sisters				
Sons/ Daughters				

Do you have any immediate family with the following: (Indicate relationship)

Cancer of the colon, rectum: Yes ☐ No ☐ no. Relationship _____
Liver disease (indicate type): Yes ☐ No ☐ no _____
Ulcerative colitis or Cohn's disease: Yes ☐ No ☐ no _____

MEDICATION HISTORY:
Are you currently taking Coumadin (Blood thinner)? Yes ☐ No ☐ Dose _____
Please indicate if you are taking non-steroidal anti-inflammatory (like Motrin or aspirin)

Medication Name	Daily Dose	How Often?

ALLERGIES: List the meds or injections that have given bad reactions. Please include your reaction (hives, rash, itching, headache, nausea, passed out, shortness of breath)

Name	Type of reaction	Year

Latex Allergy/ Sensitivity? Yes ☐ No ☐
Explain: _____

PAST HISTORY- Heart Problems

Any heart testing scheduled/performed in the last 6 months? Yes ☐ No ☐

Coronary Artery Disease	Yes ☐ No ☐	Arrhythmias	Yes ☐ No ☐
Congestive Heart Failure	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐
Emphysema/COPD	Yes ☐ No ☐	Home Oxygen	Yes ☐ No ☐
Sleep Apnea (machine use)	Yes ☐ No ☐	Asthma	Yes ☐ No ☐
Difficulty with anesthesia or intubation:			Yes ☐ No ☐
If Yes, explain: _____			
KIDNEY PROBLEMS			
Kidney insufficiency	Yes ☐ No ☐	Dialysis	Yes ☐ No ☐
OTHER MEDICAL PROBLEMS			
Diabetes	Yes ☐ No ☐	On a transplant list	Yes ☐ No ☐
Hypertension	Yes ☐ No ☐	Cancer	Yes ☐ No ☐

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE:
_____

Past Surgical History/Operations/ Year

Last Flexible **Sigmoidoscopy** Performed: Yes ☐ No ☐ Year
Last **Colonoscopy** performed: Yes ☐ No ☐
Year _____Findings _____
Last **Upper Endoscopy** Performed: Yes ☐ No ☐
Year _____Findings _____

SOCIAL HABITS (Please circle yes or No)
Do you smoke currently or past? Yes ☐ No ☐ Packs/Cigarettes/day _____
Have you stopped smoking? Yes ☐ No ☐When? _____
Do you drink alcohol? Yes ☐ No ☐ Type of Alcohol consumed _____
Amount of alcohol consumed (oz/ btl) per day/ week: _____
Do you use currently or in the past Marijuana heroin cocaine LSD Yes ☐ No ☐
If yes, please mention how long was the use and have you stopped: Yes ☐ No ☐
_____

GASTROINTESTINAL

Yes ☐ No ☐ Rectal bleeding
Yes ☐ No ☐ heartburns > 6months
Yes ☐ No ☐ Nausea
Yes ☐ No ☐ Upper abdominal pain
Yes ☐ No ☐ Diarrhea
Yes ☐ No ☐ Vomited blood
Yes ☐ No ☐ Bloating after eating
Yes ☐ No ☐ Excessive gas
Yes ☐ No ☐ Chills/fever
Yes ☐ No ☐ Night sweats
Yes ☐ No ☐ Flushing
Yes ☐ No ☐ Weakness/ tiredness

Yes ☐ No ☐ Loss of appetite
Yes ☐ No ☐ Difficult swallowing
Yes ☐ No ☐ Vomiting
Yes ☐ No ☐ Lower abdomen pain
Yes ☐ No ☐ Constipation
Yes ☐ No ☐ Black stools
Yes ☐ No ☐ Pets at home
Yes ☐ No ☐ Trouble with drinking milk
Yes ☐ No ☐ Weight loss
Yes ☐ No ☐ Itching
Yes ☐ No ☐ Usually feel depressed
Yes ☐ No ☐ Ever sought psychiatric help

PRESENT PROBLEMS:

Use the space below to describe your symptoms. If you have questions, write them down so they will not be forgotten. Thank you.

_____

_____

MID-ATLANTIC G. I. CONSULTANTS, P.A.
FINANCIAL POLICY (Please read, sign and send to us)

This Practice is dedicated to providing our patients with the best possib1e care and service while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy.

INSURANCES:

We participate with several insurance companies. Please check with the Billing Department to see if we participate with your plan. **If we do participate** with your insurance company, all services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. **All copays and deductibles are the patient's responsibility and will be billed to you by our office. HMO insurances** may require referrals for services. It is the patient's responsibility to obtain the referral prior to the time of service**. If a referral is not presented at the time of service, the patient will be responsible for payment in full for that service at the time of service**. All patients are responsible for ALL co-payments prior to services being rendered. **If we do not participate** with your insurance company, this means that we will not bill your insurance carrier and we will not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay. However, the doctor's fees may be more than what the insurance company shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient. **Payment for office visits is due at the time of service**. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company, and your doctor's bill for the services provided to you is an agreement between you and your doctor.

PAYMENT FOR SERVICES PERFORMED:

Our office accepts Visa and Master Card for your convenience, as well as cash, check, or money order. All payments are expected at the time of service and any outstanding balances are due within 30 days, unless prior arrangements have been made with the Billing Department. All **balances that reach 90 days past due will be sent to a collection agency.** Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

MISSED APPOINTMENTS POLICY:

Effective July 1, 2003, Mid-Atlantic G.I. Consultants, PA. will charge patients who miss their appointments without notifying the office within three (3) business days of their office and or procedure appointment. A charge of $25 will be rendered for a missed office visit and a charge of $50 for a missed procedure appointment. Patients will be billed directly for this charge. Payment is expected within thirty (30) days from receipt of bill.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY MID-ATLANTIC G.I. CONSULTANTS, P.A., AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____

Signature of patient or patient's financial representative **Date**

PATIENT'S MEDICARE AUTHORIZATION
(MEDICARE PATIENTS ONLY)

PATIENT'S NAME: _____

MEDICARE #: _____

I request payment of authorized Medicare benefits be make on my behalf to *Mid-Atlantic G. I. Consultants, P.A.* for any services rendered to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment(s) be made to *Mid-Atlantic G.l. Consultants,P.A.* and authorizes release of my medical information necessary to pay the claim(s). If other health insurance is indicated on the HCFA 1500 Claim Form or on an electronically submitted claim, my signature authorizes release of information to the insurer or agency shown.

In Medicare-assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I understand that I am responsible for the deductible, co-insurance and non-covered services. The co-insurance and deductible are based upon the charge determination of the Medicare carrier.

_____

Signature of patient or patient representative (only for Medicare Patients) **Date**

WE TAKE FOLLOWING INSURANCE
(FOR YOUR INFORMATION, DON'T SEND IT TO US)

AMERIHEALTH NJ HMO-POS
AMERIHEALTH ADMINISTRATORS
AMERIHEALTH
AMERICAN PROGRESSIVE (TODAYS OPTIONS)
AETNA/USHC HMO, PPO INDEMNITY
AETNA MEDICARE.
HIGHMARK BC/BS OF DE IPA, P0S, PPO, MANAGED CARE, PRE-CERT, BRAVO
BC/BS NATIONAL ACCOUNTS (CHRYSLER, GM, ETC
OUT OF STATE BC/BS WITH SUITCASE LOGO (PPO)
FEDERAL BC/BS
CHAMPUS (NOT HMO)
CIGNA HMO, PPO INDEMNITY
CORESOURCE (PHCS NETWORKS)
COVENTRY
DEFINITY HEALTH PLAN
DELAWARE PHYSICIANS CARE
DEVON HEALTH CARE
FIDELITY BENEFIT ADMINISTRATORS
FIRST HEALTH PLAN
GREAT WEST
HEALTH CARE PREFERRED
KEYSTONE
MAMSI
MDIPA/OPTIMUM CHOICE
MEDICAID (MARYLAND & DELAWARE)
MEDICARE
ONE NET PPO, PERSONAL CHOICE
PRIMARY SELECT
PRIVATE HEALTHCARE SYSTEMS (PHCS)
TRICARE (BUT NOT HMO)
UNITED HEALTH CARE PPO
UNITED HEALTH CARE COMMUNITY PLAN (DE ONLY)

WE DONOT TAKE

AMERICHOICE/AMERIGROUP/AMERICAID
BEECH STREET
CAREFIRST BC/BS BLUECHOICE PLAN
CIGNA HMO OF NJ
DIAMOND PLAN
FAMILYFIRST MARYLAND MEDICAID PLAN
EMPLOYERS HEALTH PLAN
HORIZON MERCY
ONE HEALTH PLAN
OXFORD HEALTH PLAN
INTERGROUP
MARYLAND PHYSICIANS CARE
MHIP (MARYLAND HEALTH INS PLAN)
PRIORITY PARTNERS
TRICARE HMO
PREFERRED HEALTH NETWORK (PHN)
UNITED HEALTH CARE FAMILY FIRST (MEDICAID MGD CARE)
UNITED HEALTH CARE OF MID-ATLANTIC HMO
UNITED HEALTHCARE COMMUNITY PLAN (MD, PA, NJ)

***IF YOU DO NOT SEE YOUR INSURANCE LISTED HERE, PLEASE CALL OUR OFFICE AT 302-225-2380**

NOTICE OF PRIVACY POLICIES FOR MID-ATLANTIC G. I. CONSULTANTS, P.A. (THIS PRIVACY POLICY IS FOR YOUR INFORMATION ONLY, NO NEED TO FAX/SEND BACK TO US)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). We are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit our practice, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of our practice, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of information practices upon request,
- Inspect and copy your health record,
- Amend your health record,
- Obtain a report of disclosures of your health information,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:

- Maintain the privacy of your health information,
- Provide you with this Notice which describes our legal duties and privacy practices with respect to information we collect about you,
- Abide by the terms of this Notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to revise this Notice and to make the new provisions effective for all protected health information we maintain. Should this Notice be revised, we will post a copy of the Notice and will make it available to you when you arrive for services.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization.

For More information or to Report a Problem

If you have questions and would like additional information, you may contact our Privacy Officer by contacting our office.

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Office for Civil Rights. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW.
Room 509F, HHH Building
Washington, D.C. 20201

How we may Use and Disclose Medical Information About You?

We may disclose information about you in regards to your 1. Treatment,2. Payment, and 3. HealthCare Operations.

1. **TREATMENT.**

We may use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians, or other medical personnel who are involved in taking care of you.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you arc responding to treatment.

2. PAYMENT.

We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party.

For example: A bill may be sent to you or your insurance company. The bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

3 HEALTHCARE OPERATIONS.

We may use and disclose medical Information about you in our regular course of business.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: Some of the services we provide are through contacts with business associates. Examples include services in the laboratory, radiology, emergency room, hospital, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identity, health information relevant to that person's involvement in your care or payment related to your care.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Answering Machine: We may disclose health information to you at the phone number you have provided to us. Examples: appointment reminders, answering your questions, medication changes, lab results, and as a follow up to procedures, etc.

Emergency: We may use and disclose medical information about. you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would only disclose that information to help prevent the threat.

Treatment Alternatives: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

To Report Suspected Abuse, Neglect or Domestic Violence:

We may notify government authorities if we believe that you are a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Research: With your authorization, we may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Food & Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Health Oversight and Legal: We may disclose health information for law enforcement purposes as required by Jaw or in response to a court or administrative order. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority Or attorney.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

REMINDER!!

- Please remember to include a copy of your current HEALTH INSURANCE CARD(S).

- Please-obtain and bring all required REFERRALS prior to your office visit or procedure.

- REFERRALS may be mailed, your PCP can fax referral, or you can personally bring it to our office

- COPAYS are due at time of each visit