Welcome to our practice! We hope the following information will be helpful to you. We respect your time and we would like to make your visit to our office as efficient as possible.

Location:
Parking is available in the parking garage. The entrance is to the right of the front of the building. **TOWING IN ALL OUTSIDE LOTS IS STRICTLY ENFORCED.**

Financial Policy:
We collect copays at the time of service. A $10.25 service fee will be added to copays not collected at time of service. If you have questions, please do not hesitate to contact the patient account representative at 703-766-2650 x118.

Medical Insurance:
We will file for insurance reimbursement on your behalf. Your reimbursement may not cover the full cost of your services. Regardless of insurance, payment remains your personal responsibility.

Cancellation / No-Show:
Our office sees patients by appointment only. If you are unable to keep your appointment, please notify us at least 24 hours in advance, so that we are able to offer the time to another patient. No-show for office appointments will incur a $50 fee, which will not be applied to any copay, deductible or coinsurance.

Privacy Notice:
A copy of the Privacy Notice has been enclosed.

Checklist of items to bring to your visit

- Patient Information & Signed Authorizations
- Current Insurance card and photo ID
- Insurance referral if needed
- Financial Policy
- Medical Information & Signed Patient Statement
- **If you are being referred for any abnormal labs or radiology findings you must bring a copy of the report with you to the office visit. Although you may have requested them from your referring doctor, they often times do not reach our office prior to your visit.**

If you have any questions regarding the above, or if we can be of further help, please do not hesitate to call our office at (703) 435-3366.

We look forward to meeting you.
PATIENT INFORMATION

Patient Full Name: ____________________________  DOB: ___________  AGE: ___

Address: ____________________________________________________________

City  State  Zip

Home #: ____________________  Work #: _______________  Cell #: _______________

SS #: ______________________  □ Male  □ Female  Marital Status:  S  M  D  W

Email Address: _______________________________________________________

Preferred Language: _________________  Race: _________________  Ethnicity: Hispanic or Latino

Non Hispanic or Latino

Employer: ___________________________  Occupation: ______________________

Emergency Contact: ___________________________  Phone #: __________________

Primary Care Physician: ____________________  City, State: ___________________

Referring Physician: ________________________  City, State: ___________________

Primary Insurance Information:  Secondary Insurance Information:

Ins Name: ____________________________  Ins Name: ______________________

ID #: ________________________________  ID #: ______________________

Group #: _____________________________  Group #: ______________________

Policy Holder Name: ____________________  Policy Holder Name: ______________

Relation to Pt: _________________________  Relation to Pt: ___________________

Holders DOB: _________________________  holders DOB: ___________________

Holders SS #: _________________________  Holders SS #: ___________________

Authorization for Disclosure of Protected Health Information

I authorize the Gastroenterology Group to disclose my protected health information to:

Name: ____________________________  Relation: ________________  Phone #: ____________

Name: ____________________________  Relation: ________________  Phone #: ____________
Authorization and Acknowledgement  (Please initial)

_______ AUTHORIZATION: I / We hereby state that the information provided is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

_______ AUTHORIZATION: I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified, I am responsible for all charges incurred.

_______ ACKNOWLEDGEMENT OR RECEIPT OF PRIVACY NOTICE: I hereby acknowledge receipt of the Notice of Privacy Practices (attached) given to me by the above company.

☐ Consent refused by patient, Witness by: ____________________________

_________________________________  ____________________________  ______________________
Signature of Patient / Printed Name  Date
Legal Representative
Welcome to The Gastroenterology Group, PC and thank you for choosing us! We appreciate your confidence and goodwill. To ensure that we have financial stability and can continue to provide medical services to the community and region, the following policies shall be enforced:

**Uninsured Patients:**
- All Charges are due and payable at the time of service. We accept cash, check and major credit cards. We may reschedule the appointment if payment is not made prior to the service rendered.

**Patients with insurance:**
- The physicians will bill insurance plans as a courtesy to their patients if the patient provides the required insurance information at the time of service and signs the assignment of benefits statement. *Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.*
- There will be a $10.25 service fee added for copays not paid at the time of service.
- It is the patient’s responsibility to determine whether a referral is required, and the referral can be requested from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time you will have the option of paying for your visit or rescheduling.
- If the patient’s insurance rejects, denies or covers only a portion of treatment, the patient shall be responsible for immediate payment of the balance due. A pre-treatment deposit may be required.

**No-Show and Cancellation Policy:**
- If the patient fails to cancel his/her procedure at least 5 business days in advance or is a no-show, the patient is responsible for $250 fee which will not be applied to any copay, deductible or coinsurance.
- If the patient reschedules within 2 business days of his/her procedure, the patient is responsible for $100 fee which will not be applied to any copay, deductible or coinsurance.
- If the patient is a no-show for any office appointment, the patient is responsible for a $50 fee, which will not be applied to any copay, deductible or coinsurance.

**Delinquent / Unpaid Account:**
- Prior to providing services, payment of prior outstanding accounts will be requested and should be received. Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically urgent.
- Accounts which cannot be collected by the physician after normal in-house collection procedures may be referred to a collection agency, magistrate or attorney for further collection action in accordance with the established guidelines. All delinquent accounts over 30 days will incur a service fee. Accounts referred to collection will also incur a collection fee. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within (30) thirty days of billing.

**Refunds:**
- Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients’ refunds will not be processed until all active or past due accounts are paid in full.
Insurance / Disability Forms:
- There will be a $25 handling fee to cover the administrative fee for writing a letter or filling out claims forms, such as insurance forms or disability forms (except Medicare patients). The fee is due once the form is completed, and the patient will be directly responsible for this fee.

Returned Checks:
- Checks returned to The Gastroenterology Group, PC for insufficient funds, closed account, stopped payment, or any other reason will be subject to a $25 fee.

Medical Records:
- Virginia state rates apply for processing medical records. The first 50 pages will be charged at $.50 per page, all pages over 50 will be charged at $.20 per page. A $7.00 search and handling fee plus first class postage applies. Request will be completed within (15) business days.

I, the patient/patient legal representative, understand and agree to abide by the financial policy set forth.

_______________________________  _________________________________  ______________________
Signature of Patient/Legal Patient Name Date
Representative
MEDICAL HISTORY FORM

Patient’s Name: __________________________  Today’s Date: _____________  Last Visit Date: _____________

Date of Birth: ___________  Age: ______  Sex:  M / F  Referring Physician: _________________________

REASON OF TODAY’S VISIT: _______________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

PERSONAL MEDICAL HISTORY  Please check all that apply

☐ Anemia
☐ Barrett’s Esophagus
☐ Cirrhosis
☐ Colitis
☐ Colon Polyps
☐ Crohn’s Disease
☐ Diarrhea – Chronic
☐ Diverticulitis
☐ Diverticulosis
☐ Elevated Liver Enzymes
☐ Gallstones
☐ GI Bleed – Upper
☐ GI Bleed – Lower
☐ GERD (Reflux)
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Irritable Bowel Syndrome
☐ Liver Disease
☐ Pancreatitis
☐ Peptic Ulcer Disease
☐ Ulcerative Colitis
☐ Hx of Breast Cancer
☐ Hx of Cervical Cancer
☐ Hx of Colon Cancer
☐ Hx of Esophageal Cancer
☐ Hx of Gastric Cancer
☐ Hx of Prostate Cancer
☐ Anxiety
☐ Asthma
☐ Atrial Fibrillation
☐ Autoimmune Disorder
☐ C H F
☐ COPD/Emphysema
☐ Coronary Artery Disease
☐ CVA / Stroke
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ D V T
☐ Endocarditis
☐ High Cholesterol
☐ Myocardial Infarction
☐ High Blood Pressure
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Kidney Disease
☐ Kidney Stone
☐ Neurologic Disorder
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Seizure Disorder
☐ Tuberculosis
☐ Valvular Heart Disease
☐ Other: ______________________
☐ NONE OF THE ABOVE

SURGICAL HISTORY AND HOSPITALIZATIONS

☐ None
☐ Please list all surgeries/hospitalizations, dates and reasons

__/__/____  _______________________________________________________________
__/__/____  _______________________________________________________________
__/__/____  _______________________________________________________________

FAMILY HISTORY  Check all that apply. Indicate family member(s) and age of diagnosis

Colon Cancer __________________________  Stomach Cancer _______________________
Colon Polyps __________________________  Liver Disease _________________________
Crohn’s Disease _______________________  Pancreatitis _______________________ 
Diverticulitis __________________________  Ulcerative Colitis ____________________
Diverticulosis __________________________  Ulcers _____________________________
Gallbladder Disease ____________________  Other _____________________________
### SOCIAL HISTORY

Check all that apply:

- **Tobacco**
  - □ Current every day smoker
  - □ Current some day smoker
  - □ Former smoker
  - □ Never smoker
  - □ Smoker – current status unknown
  - □ Unknown if ever smoked

- **Alcohol use**
  - □ No
  - □ Yes
    - (Type __________) (Drinks per day _______) (Drinks per week __________)

- **Caffeine**
  - □ No
  - □ Yes
    - (Drinks per day __________)

- **Exercise**
  - □ No
  - □ Yes
    - (Type __________________) ( ________ times per week)

- **Tattoos**
  - □ No
  - □ Yes

---

**Occupation:**___________________  **Marital Status:**  __________  **Number of Children:**  __________

**Special interest or hobbies:** ____________________________________________________________

---

### BOWEL HABITS

How many bowel movements do you have per day? _________________

Circle those things that pertain to your bowel movements:

- Blood
- Mucus
- Black Stools

Are you currently experiencing any of these symptoms? Please check all that apply:

<table>
<thead>
<tr>
<th>GI</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Difficulty swallowing</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Pain on swallowing</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Lump in throat</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Nausea</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Vomiting</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Indigestion/heartburn</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Vomiting blood</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Abdominal pain</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Jaundice</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Gas/bloating</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Diarrhea</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Constipation</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Change in bowel habits</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Bloody stools</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Black stools</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Rectal Bleeding</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Fecal incontinence</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Mucous in stools</td>
<td></td>
</tr>
</tbody>
</table>

**GENERAL**

| □ | Fever |
| □ | Chills |
| □ | Sweats |
| □ | Anorexia |
| □ | Fatigue |
| □ | Weight loss |
| □ | Weight gain |

**EYES**

| □ | Blurring |
| □ | Discharge |
| □ | Eye pain |
| □ | Glaucoma |

**ENT**

| □ | Ear ache |
| □ | Tinnitus |
| □ | Frequent nosebleeds |
| □ | Sore throat |
| □ | Hoarseness |

**CARDIO**

| □ | Chest pain/angina |
| □ | Palpitations |
| □ | Syncope |
| □ | Swelling of legs |
| □ | Heart murmur |
| □ | Valve disease |

**RESP**

| □ | Sleep apnea |
| □ | Diagnosed by Sleep Study? Yes / No |
| □ | Shortness of breath |
| □ | Cough |
| □ | Wheezing |
| □ | Coughing up blood |

**GU**

| □ | Urinary burning |
| □ | Blood in urine |
| □ | Urinary frequency |
| □ | Urinary hesitancy |
| □ | Nocturnal urination |
| □ | Urinary incontinence |

**NEURO**

| □ | Weakness |
| □ | Seizures |
| □ | Syncope |
| □ | Vertigo |
| □ | Frequent headaches |

**ENDO**

| □ | Cold intolerance |
| □ | Heat intolerance |
| □ | Excessive thirst |
| □ | Unusual weight change |

**HEME**

| □ | Easy bruisability |
| □ | Uncontrolled bleeding |
| □ | Enlarged lymph nodes |
| □ | History of blood clots |
| □ | Anemia |

**MS**

| □ | Joint pain |
| □ | Joint swelling |
| □ | Back pain |

**DERM**

| □ | Rash |
| □ | Itching |
| □ | Unhealing ulcers |

**PSYCH**

| □ | Depression |
| □ | Anxiety |
| □ | Suicidal thoughts |
CURRENT MEDICATIONS
Please list your medications and dosages for each. Include over the counter medications and supplements.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Medication Name</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any drug allergies? ___________________ Any other allergies? ___________________

Pharmacy Name: __________________________ Street Address: ______________________________

PROCEDURE HISTORY
When was your last procedure? What were the results?

☐ Colonoscopy _____/_____/_____ Normal or ____________________________

☐ Upper Endoscopy (EGD) _____/_____/_____ Normal or ____________________________

☐ Flexible Sigmoidoscopy _____/_____/_____ Normal or ____________________________

☐ I have never had any endoscopies

The medical information provided is complete and true to my knowledge.

Patient Signature ____________________________ Date ___________________

FOR OFFICE USE ONLY
Height: ______ Weight: ______ BMI: ______ BP: _______ Temp: ________ Pulse: ________

Allergies: ____________________ Sleep Apnea: ☐ Yes ☐ No

Reason for procedure: ☐ Screening (V76.51) ☐ Family Hx Colon Cancer (V16.0)

☐ Personal Hx of Polyps (V12.72) ☐ Other ____________________________

Staff Signature: ____________________________ Date: ___________________