THE GASTROENTEROLOGY GROUP, PC
Advanced Digestive Care, LLC
1939 Roland Clarke Place, Suite 200
Reston, VA 20191
(703) 435-3366 / (703) 766-2650

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:

When visiting our office, you'll want to park in the parking lot directly in front of the building. Once you enter the building, go straight down the main lobby hall (towards the large windows) and the elevators will be on your right. Select level "2" and our reception desk will be directly to your right upon exiting the elevators.

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 may 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!

ADVANCED DIGESTIVE CARE

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:

Ins Name: _____

ID #: _____

Group #: _____

Policy Holder Name: _____

Relation to Pt: _____

Holders DOB: _____

Holders SS #: _____

Secondary Insurance Information:

Ins Name: _____

ID #: _____

Group #: _____

Policy Holder Name: _____

Relation to Pt: _____

Holders DOB: _____

Holders SS #: _____

Authorization for Disclosure of Protected Health Information

I authorize the Gastroenterology Group a member of Advanced Digstive Care, LLc 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 / Legal Representative	Printed Name	Date

ADVANCED DIGESTIVE CARE

FINANCIAL POLICY

Welcome to The Gastroenterology Group, PC, a member of Advanced Digstive Care, LLC 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 Representative	Patient Name	Date

MEDICAL HISTORY FORM

Patient's Name: _____ Today's Date: _____ Last Visit Date: _____

Date of Birth: _____ Age: _____ Sex: M / F Referring Physician: _____

REASON OF TODAYS VISIT: _____

_____

_____

PERSONAL MEDICAL HISTORY

Please check all that apply

- ☐ Anemia
- ☐ Barretts Esophagus
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Diarrhea – Chronic
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Elevated Liver Enzymes
- ☐ Gallstones
- ☐ GI Bleed – Upper
- ☐ GI Bleed – Lower
- ☐ GERD (Reflux)
- ☐ Hepatits 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 _____

Colon Polyps _____

Crohn's Disease _____

Diverticulitis _____

Diverticulosis _____

Gallbladder Disease _____

Stomach Cancer _____

Liver Disease _____

Pancreatitis _____

Ulcerative Colitis _____

Ulcers _____

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

GI

Y	N	
☐	☐	Difficulty swallowing
☐	☐	Pain on swallowing
☐	☐	Lump in throat
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Indigestion/heartburn
☐	☐	Vomiting blood
☐	☐	Abdominal pain
☐	☐	Jaundice
☐	☐	Gas/bloating
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Change in bowel habits
☐	☐	Bloody stools
☐	☐	Black stools
☐	☐	Rectal Bleeding
☐	☐	Fecal incontinence
☐	☐	Mucous in stools

GENERAL

Y	N	
☐	☐	Fever
☐	☐	Chills
☐	☐	Sweats
☐	☐	Anorexia
☐	☐	Fatigue
☐	☐	Weight loss
☐	☐	Weight gain

EYES

Y	N	
☐	☐	Blurring
☐	☐	Discharge
☐	☐	Eye pain
☐	☐	Glaucoma

ENT

Y	N	
☐	☐	Ear ache
☐	☐	Tinnitus
☐	☐	Frequent nosebleeds
☐	☐	Sore throat
☐	☐	Hoarseness

CARDIO

Y	N	
☐	☐	Chest pain/angina
☐	☐	Palpitations
☐	☐	Syncope
☐	☐	Swelling of legs
☐	☐	Heart murmur
☐	☐	Valve disease

RESP

Y	N	
☐	☐	Sleep apnea

Diagnosed by Sleep Study? Yes / No

☐	☐	Shortness of breath
☐	☐	Cough
☐	☐	Wheezing
☐	☐	Coughing up blood

GU

Y	N	
☐	☐	Urinary burning
☐	☐	Blood in urine
☐	☐	Urinary frequency
☐	☐	Urinary hesitancy
☐	☐	Nocturnal urination
☐	☐	Urinary incontinence

NEURO

Y	N	
☐	☐	Weakness
☐	☐	Seizures
☐	☐	Syncope
☐	☐	Vertigo
☐	☐	Frequent headaches

ENDO

Y	N	
☐	☐	Cold intolerance
☐	☐	Heat intolerance
☐	☐	Excessive thirst
☐	☐	Unusual weight change

HEME

Y	N	
☐	☐	Easy bruisability
☐	☐	Uncontrolled bleeding
☐	☐	Enlarged lymph nodes
☐	☐	History of blood clots
☐	☐	Anemia

MS

Y	N	
☐	☐	Joint pain
☐	☐	Joint swelling
☐	☐	Back pain

DERM

Y	N	
☐	☐	Rash
☐	☐	Itching
☐	☐	Unhealing ulcers

PSYCH

Y	N	
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Suicidal thoughts

CURRENT MEDICATIONS

Please list your medications and dosages for each. Include over the counter medications and supplements.

Medication Name	*Dosage*	*Medication Name*	*Dosage*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: _____
