GASTROCARE, P.C.

A.B. REDDY, M.D., F.A.C.G. REKHA KHURANA, M.D. SUBHASH BAJAJ, M.D. CHARLES WILCOX. M.D.

Referring Physician: _____

First Name: _____ **Last name:** _____

Date of Birth: _____ **Age:** _____

Pharmacy Name and Location: _____ **Pharmacy Fax Number:** _____

Your Email Address: _____

Gender: Male Female

Race: American Indian / Alaskan Native / Asian_____ / African American / Caucasian / More than one race / Pacific Islander / Indian / Middle Eastern / Declined

Ethnicity: Hispanic / Latino / Non-Hispanic / Declined

Language: English / Spanish / Other

Contact Preference: Home #: _____ Cell #: _____ Office #: _____

REASON FOR VISIT: _____

_____

Allergies & Reactions: _____ _____

_____ _____

Current Medications (Name/Dose/How taken): _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Diagnostic Studies/Tests: _____ _____

_____ _____

_____ _____

_____ _____

Pneumococcal Vaccine: Yes / No Date: _____

Flu Vaccine: Yes / No Date: _____

Past or Present Medical Conditions:

Cancer:	Yes	No	Type:_____
Peptic Ulcer:	Yes	No	
Heart Attack:	Yes	No	
Diabetes:	Yes	No	
High Blood Pressure:	Yes	No	
Hepatitis:	Yes	No	Type:_____
Stroke:	Yes	No	
Emphysema:	Yes	No	
Seizures:	Yes	No	
Colon Polyps:	Yes	No	
Ulcerative Colitis	Yes	No	
Irritable Bowel Syndrome	Yes	No	
Crohn's:	Yes	No	
HIV:	Yes	No	
Thyroid Problems:	Yes	No	
Sleep Apnea:	Yes	No	
Blood Clots:	Yes	No	
Pace Maker:	Yes	No	
Defibrillator	Yes	No	

Other Medical Conditions:_____

Gastrointestinal Symptoms:

None:	Yes	No
Black Stool:	Yes	No
Difficulty Swallowing:	Yes	No
Loss of appetite:	Yes	No
Abdominal Pain:	Yes	No
Abdominal Swelling:	Yes	No
Change in bowel habits:	Yes	No
Constipation:	Yes	No
Diarrhea:	Yes	No
Gas:	Yes	No
Heartburn/reflux:	Yes	No
Jaundice:	Yes	No
Nausea:	Yes	No
Rectal bleeding/blood in stool:	Yes	No
Stomach Cramps:	Yes	No
Vomiting:	Yes	No
Blood in vomit:	Yes	No
Weight Loss:	Yes	No

Review of Systems:

Allergic/Immunologic:

HIV exposure	Yes	No
strong allergic reactions	Yes	No

Cardiovascular:

chest pain	Yes	No
dyspnea with exercise	Yes	No
irregular heart beat	Yes	No
palpitations	Yes	No
orthophea	Yes	No
peripheral edema	Yes	No
syncope	Yes	No

Constitutional:

fatigue	Yes	No
fever	Yes	No
loss of appetite	Yes	No
weight loss	Yes	No

ENMT:

ear pain	Yes	No
nose bleeds	Yes	No
photophobia	Yes	No
sore throat	Yes	No
difficulty swallowing	Yes	No
loss of vision	Yes	No

Endocrine:

excessive thirst	Yes	No
hair loss	Yes	No
heat intolerance	Yes	No
diabetes	Yes	No

Genitourinary:

frequent urination	Yes	No
hematuria	Yes	No
difficulty urinating	Yes	No
blood in urine	Yes	No
kidney stone	Yes	No
endometriosis	Yes	No

Hematologic/Lymphatic:

easy bruising	Yes	No
prolonged bleeding	Yes	No

Integumentary:

allergies	Yes	No
dryness	Yes	No
hives	Yes	No
jaundice	Yes	No
rashes	Yes	No

Musculoskeletal:

arthritis	Yes	No
lupus	Yes	No
fibromyalgia	Yes	No

Neurological:

dizziness	Yes	No
fainting	Yes	No
frequent headaches	Yes	No
migraines	Yes	No
seizures	Yes	No

Psychiatric:

anxiety	Yes	No
depression	Yes	No
difficulty sleeping	Yes	No
nervousness	Yes	No
panic attacks	Yes	No
stress factors	Yes	No

Respiratory:

asthma	Yes	No
cough	Yes	No
dyspnea	Yes	No
shortness of breath (w/ exercise)	Yes	No
wheezing	Yes	No

Previous Colonoscopies (Date): _____

Previous EGDs (Date): _____

Previous Surgeries (Date): _____

_____

Social History:

Occupation: _____

Marital Status: Single / Married / Divorced / Widowed

Alcohol: None | Duration: _____ Type: _____ Quantity: _____ Frequency: _____

Caffeine: None | Duration: _____ Type: _____ Quantity: _____ Frequency: _____

Tobacco: Current Every Day Smoker / Former Smoker / Never Smoked / Chew Tobacco

Quantity: _____ How long: _____

Recreational Drug Use: Never / In Past / Current Use If yes, type: _____

Family Medical History: Family history noncontributory Yes No

			Relationship:	**Type:**
Peptic Ulcer	Yes	No	_____	_____
Colon Polyps	Yes	No	_____	_____
Colon Cancer	Yes	No	_____	_____
Stomach Cancer	Yes	No	_____	_____
Esophageal Cancer	Yes	No	_____	_____
Irritable Bowel Disease	Yes	No	_____	_____
Ulcerative Colitis	Yes	No	_____	_____
Crohn's	Yes	No	_____	_____
Liver Disease/Cirrhosis	Yes	No	_____	_____
Other Cancers, type	Yes	No	_____	_____

GASTROCARE P.C. / TUSCALOOSA ENDOSCOPY CENTER

PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____ City: _____
First Last

Primary Care Physician: _____ City: _____
First Last

Did you bring with you today the written referral from your Referring Physician? ☐ Yes ☐ No

PATIENT INFORMATION

Patient's Social Security #: _____ Date of Birth: _____ Gender: ☐M ☐F

Name of Patient: _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Work Phone: (___) _____

Employer: _____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Responsible Party: _____
(If different from patient) First Middle Last

Social Security #: _____ Date of Birth: _____ Gender: ☐M ☐F

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Work Phone: (___) _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____
First Middle Last

Relationship to patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Work Phone: (___) _____

GASTROCARE P.C. / TUSCALOOSA ENDOSCOPY CENTER

PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

INSURANCE COVERAGE PRIMARY

Please present your insurance card(s) and Driver's License during check-in

Name of Insurance: _____ Group Name: _____

Patient's Relationship to Policyholder: ☐Self ☐Child ☐Spouse ☐Guardian ☐Other

Name of Policyholder: _____

Date of Birth of Policyholder: _____ Employer of Policyholder: _____

INSURANCE COVERAGE SECONDARY

Please present your insurance card(s) and Driver's License during check-in

Name of Insurance: _____ Group Name: _____

Patient's Relationship to Policyholder: ☐Self ☐Child ☐Spouse ☐Guardian ☐Other

Name of Policyholder: _____

Date of Birth of Policyholder: _____ Employer of Policyholder: _____

I/ We hereby authorize GastroCare P.C. / Tuscaloosa Endoscopy Center to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient.

I/We authorize payment of medical benefits to GastroCare P.C. / Tuscaloosa Endoscopy Center.

I/We understand that should my account have to be referred to an attorney for collection that I/We are responsible for all fees and costs incurred therein.

I/We hereby authorize GastroCare P.C. / Tuscaloosa Endoscopy Center to act on my behalf in accessing hospital records when and if needed.

_____ _____

Date Patient or Responsible Party

GASTROCARE, P.C.

and

TUSCALOOSA ENDOSCOPY CENTER

AUTHORIZATION FOR TREATMENT

The undersigned gives consent for the treatment considered necessary for the patient whose name appears on the bottom and that the treatment and procedures will be performed by the above practice physician, and whomever he may designate as assistants. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance is made as to the results that may be obtained.

Printed Name of Patient _____ Date _____

Signature of Patient or Authorized Person _____ Witness _____

Relationship to Patient _____

****

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted to release to the Primary or Consulting / referring Physician such information as may be necessary for the completion of my hospitalization claims.

Signature of Patient or Authorized Person _____ Relationship to Patient _____

****

AUTHORIZATION TO PAY THE PHYSICIAN / FACILITY

I hereby authorize payment for services provided in the office, endoscopy center and the hospital directly to the above physician, otherwise payable to me. I understand I am fully responsible for the medical and / or physician charges not covered by this authorization.

Signature of Patient or Authorized Person _____ Relationship to Patient _____

****

PRIVACY POLICY RECEIPT

I have received, read, and understand the notice of the Privacy Policies.

Signature of Patient or Authorized Person _____ Relationship to Patient _____

****

All authorizations must be signed by the patient or by an authorized person in the case of a minor or when a patient is physically or mentally incapable.

GASTROCARE, P.C. (GRC) AND
TUSCALOOSA ENDOSCOPY CENTER (TEC)

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I (we), the undersigned patient and/or responsible party hereby authorize GASTROCARE, P.C. / TUSCALOOSA ENDOSCOPY CENTER, it's physician's, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc to the person or persons indicated below:

_____ Spouse Name _____

_____ Parent(s) Name(s) _____

_____ Children Name(s) _____

_____ Other Name(s) _____

May we leave medical information on you answering machine? YES / NO

May we release medical information to an individual about your procedure, if they come with you for a procedure? YES / NO

Patient Signature: _____ Date: _____

******* _____ DO NOT DISCUSS OR RELEASE ANY OF MY MEDICAL INFORMATION TO ANYONE EXCEPT MYSELF.

ACKNOWLEDGMENT & CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from GASTROCARE, P.C. (GRC) / TUSCALOOSA ENDOSCOPY CENTER (TEC). You agree that records concerning your care within GRC and/or TEC shall remain the property of TEC and/or GRC. You understand and agree that such information is used for: (1) your treatment – the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient, (2) payment for your services – billing, claims management, medical data processing, reimbursement, and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account, (3) routine healthcare operations – including, but not limited to, quality assurance, utilization review, medical review, internal auditing, medical research and educational purposes. You acknowledge that you have been provided with a GRC/TEC Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand GRC/TEC reserves the right to change the Notice and GRC/TEC will provide you with a revised Notice when you come to TEC/GRC. You have the right to request we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____

TEC/GRC: Agree _____ Do Not Agree _____

_____ _____

Signature of Patient Date

Tuscaloosa Endoscopy Center

Date _____ Chart Number_____

1. I _____have received a copy of my rights and responsibilities and contact information regarding where and whom I may be able to express my concerns, complaints , and or grievances to. Any questions, and/or concerns will be my responsibility to bring it to the attention of the appropriate staff. **Initials**_____

2. Because of the nature of our center and because each procedure is elective, it is the policy of Tuscaloosa Endoscopy Center to not honor Advance Directives. If you have an advance directives please bring it with you on the day of the procedure so we may have it for our records. Information on advance directives can be obtained from www.advdir.com. Any questions, concerns and/or disagreements to these terms will be my responsibility to bring it to the attention of appropriate staff.

I have an advance directive **Yes** _____ **No** _____
If yes, did you bring a copy with you today? **Yes** _____ **No** _____ **Initials**_____

3. I have been given information about the organization's ownership. Any questions, and/or concerns will be my responsibility to bring it to the attention of the appropriate staff. Initials_____

4. I have been given information about the organization's complaints and Grievances procedure. Any questions, and / or concerns will be my responsibility to bring it to the attention of the appropriate staff. **Initials**_____

5. I have received written documentations of the items listed above, prior to my scheduled initial consultation and / or my procedure date. By signing below, I state my understanding and agreement to the above documents, in regards to Tuscaloosa Endoscopy center policies and procedures. I am validating that each initials next to the corresponding documents listed above were written by me. Furthermore, I have understood that should I have any questions regarding its content I should contact appropriate management or staff for clarifications.

_____

Patient Signature

_____ _____

Witness Signature **Witness Name**

GastroCare, P.C.

A. B. Reddy, M.D., F.A.C.G.*, A.G.A.F, F.A.S.G.E.

Rekha Khurana, M.D., • Subhash Bajaj, M.D.

Riverwood Professional Center
120 Rice Mine Road N
Tuscaloosa, AL 35406
Phone (205) 345-0010 • Fax (205) 752-1175

Dear Client:

We appreciate your confidence in choosing GastroCare, P.C. for your gastroenterology care. We have an ambulatory endoscopy center, Tuscaloosa Endoscopy Center, that is affiliated with us. Tuscaloosa Endoscopy Center is accredited by the Accreditation Association for Ambulatory Health Care and is a Medicare approved ambulatory surgery and endoscopy center.

Your procedure will be scheduled at Tuscaloosa Endoscopy Center, unless you request another facility or unless you meet one of the following criteria: 1) Your insurance does not include coverage for Tuscaloosa Endoscopy Center. 2) Based on your medical condition, our physicians and practitioners determine that you should have your procedure done in a hospital setting. Some examples of underlying conditions that would limit your ability to have a procedure done at Tuscaloosa Endoscopy Center include having a body mass index (BMI) of 50 or above; having a defibrillator; having chronic kidney disease that requires dialysis. There may be other medical conditions not listed here that would require you to have your procedure done elsewhere. Your physician will make that judgment with your best interest in mind.

Please inform your physician or practitioner if you have any questions. We look forward to serving you now and in the future.

Please check one option below, then sign, date, and return to our staff.

___ I would like to schedule my procedure at Tuscaloosa Endoscopy Center.

___I would like to schedule my procedure at another facility.

_____ _____

Patient Signature Date

GastroCare, P.C.

A. B. Reddy, M.D., F.A.C.G.*, A.G.A.F, F.A.S.G.E.

Rekha Khurana, M.D., • Subhash Bajaj, M.D.

Riverwood Professional Center
120 Rice Mine Road N
Tuscaloosa, AL 35406
Phone (205) 345-0010 • Fax (205) 752-1175

Dear Valued Patient,

Thank you for coming to our practice to be seen with your Gastroenterolgy symptoms. Many patients that come to our office need endoscopy procedures. If you need an endoscopy procedure we would like to do the endoscopy at our sister facility, Tuscaloosa Endoscopy Center, which is in the same building as GastroCare, P.C. The Tuscaloosa Endoscopy center is accredited by the Accreditation Association for Ambulatory Health Care. If you have a preference for another facility please let us know. In the physicians judgment, if it is safer to do the procedure at a hospital setting then our doctors will certainly let you know. If you prefer to have it done at the hospital please let us know, otherwise we will schedule at our facility as long as it is safe to do so. If you have any insurance issues please bring it to our attention. We appreciate the confidence that you have placed with our practice and our physicians. We look forward to serving you now as well as in the future.

Best Regards,

Management
GastroCare P.C.

Tuscaloosa Endoscopy Center

Dear Patient,

Our staff sincerely, hopes that your visit with us is pleasant and that we meet your expectations. If you have not received one of our procedure information brochures, you may pick up one in our waiting area or ask one of our receptionist.

The Center was established and built by Dr. Adisesha B. Reddy to serve his patients more effectively, and he remains the owner of Tuscaloosa Endoscopy Center. It is part of our Vision and Philosophy to provide you with high quality efficient outpatient surgical services. As part of that Vision and Philosophy we request that you, share any concerns or compliments that affect your care here at the center. Each compliment or concern will be followed up in a timely manner.

Because of the nature of our center and because each procedure is elective, regardless of an Advance directive formulated by a patient it is the policy of Tuscaloosa Endoscopy Center to resuscitate and transfer patients to a near by hospital.

Please contact us at 205 345 0012 if you have any questions regarding your insurance or financial arrangements prior to your procedure.

Again the employees of Tuscaloosa Endoscopy Center thank you for allowing us to serve your Endoscopy needs.

Sincerely,

Tuscaloosa Endoscopy Center