Clarence Butch Dunn, Jr., M.D.
302 McMillan Road
West Monroe, LA. 71291
318-322-2202 - Phone
318-322-9949 - Fax

Welcome to Our Practice!

We appreciate you choosing us for your healthcare needs.

The following are all the forms necessary for your upcoming visit or procedure. Please bring the completed forms with you to your appointment. We want as much of your appointment time to be spent with the physician, not doing administrative work! All patients scheduled for an appointment or procedure will receive a **HIPAA secure text** from our office **2** days prior to confirm your appointment / procedure. If we do not receive a response via text, we will call you.

Direct Referral Colonoscopy Screening or EGD

Thank you for choosing to schedule with Dr. Dunn. With our Direct Referral program, prior office visits or consultations with our physician are not necessary in most cases, we can directly schedule your Colonoscopy or EGD. If you have a scheduled procedure with Dr. Dunn, you must complete our paperwork 5-7 days prior by either filling out the forms at our office or by receiving it via text through **Klara**, our HIPAA secure texting platform.

Insurance and Billing

When you contact us, we verify whether we are part of your insurance network, or let you know otherwise. We accept **most** major insurances with the **exception** of MEDICAID. For planned procedures, we also routinely check your insurance for coverage once all paperwork and insurance information is received. We will file all insurance you have on file with us, but the final decision about whether a claim gets paid is up to your health plan. Regardless of the extent of the insurance coverage, the patient is responsible for the entire balance.

Payment Options

Charges for consultations and office visits are determined by the time spent with the doctor and takes into account the complexity of the problem. **The fees which are due at the time of service include co-payments required by insurance, and deductibles; also services your insurance does not pay us for.** All out of pocket expenses for consultations and office visits are payable at the time services are rendered. **Fees for procedures are due at least three (3) days prior to your scheduled procedure**. Any unpaid balance will be subject to 1.5% finance charge and any collection fees. **We accept most major credit cards, debit cards, cash, or checks**. There is a **3.5% fee** for **credit card** charges. This fee does **NOT** apply to debit cards, cash, or checks.

Cancellation Policy

This office enforces a cancellation policy by assessing a cancellation fee for any no show appointments or procedures, as well as any cancellations that do not meet the twenty-four (24) hour notice policy. **Cancellation fees for procedures are $100.00 and office appointments are $50.00.** These will be added to your account and collected in the usual manner. By signing, you agree to the terms of this policy. All questions concerning your account will be addressed to the billing office. The physician is here for your medical needs ONLY.

Certificate

The undersigned certified that he / she has read and understood the foregoing and fully accepts the terms specified above.

_____ _____

PRINT NAME **DATE / TIME**

_____

SIGNATURE

Patient Information Form

First Name: _____ MI: _____ Last Name _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell #: _____ Work #: _____
Date of Birth: _____ Age: _____ Marital Status: _____
Social Security #: _____ Patient's Employer: _____
Spouse's Name: _____ Spouse's Date of Birth: _____ Spouse SSN: _____
Spouse's Employer: _____ Spouse's Work #: _____ Spouse Cell #: _____
Emergency Contact (other than spouse): _____ Relationship: _____
Emergency Contact Phone #: _____ Emergency Contact Cell #: _____
Referring Physician: _____
Reason for your visit today: _____
Are you currently on a blood thinner? YES / NO If so, how long? _____

Family History

Do you have a family history of any of the following?

Cancer: _____ Lung Disease: _____
Heart Disease: _____ Kidney Disease: _____
Hypertension: _____ Diabetes: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of surgical and/or medical benefits directly to Clarence Butch Dunn Jr., MD APMC, Gastroenterology Clinic and Endoscopy Clinic of Monroe, APMC (herein CBD, GCM and/or ECM) and/or Endoscopy Center of Monroe Inc, further convey, transfer and assign all of my rights in my insurance coverage to Clarence Butch Dunn Jr., MD APMC and to Clarence Butch Dunn Jr., MD APMC and to Gastroenterology Clinic and Endoscopy Clinic of Monroe, APMC for service rendered. I also hereby assign and transfer any and all rights, title, and interest to any claim for penalties and/or attorney fees arising under any state or federal law or regulation related to the payment of any claim for benefits to Clarence Butch Dunn Jr., MD APMC, Gastroenterology Clinic and Endoscopy Clinic of Monroe, APMC. Regardless of the extent of the insurance coverage, I agree to be responsible for the entire balance. I also authorize release of information pertaining to my claim to my insurance company and/or companies or my attorney. Once the physician has obtained the patient's one time authorization, he may submit any later claim on either an assigned or unassigned basis without obtaining any additional signature from the patient. In submitting claims, he should indicate "Patient request for payment on file." I hereby authorize CBD, GCM and/or ECM to furnish information to any requesting physician.

X_____ Date: _____

MEDICARE AUTHORIZATION

I certify that the information given by me in applying for a payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf once the physician has obtained the patient's one time authorization, he may submit any later medicare claim on either an assigned or unassigned basis without obtaining any additional signature from the patient in submitting claims, he should indicate " Patient request for payment on file." I hereby authorize Clarence Butch Dunn Jr., MD APMC, Gastroenterology Clinic and Endoscopy Clinic of Monroe, APMC to furnish information to any requesting physician.

X_____ Date: _____

Dr. Clarence Butch Dunn, Jr. M.D. & Endoscopy Centers of Monroe / West Monroe, Inc.
Notice of Privacy Practices Acknowledgement

I, (**Print Patient Name**) _____, acknowledge receipt of the Notice of Privacy Practices.
By: (**Signature of Patient**): _____ **Date:** _____

CLARENCE BUTCH DUNN Jr., M.D.
Gastrointestinal Specialist
302 McMillan Road
West Monroe, LA 71291
318-322-2202 office 318-322-9949 fax

INDIVIDUAL PATIENT'S AUTHORIZATION

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Your Name _____

Your Street Address _____

Your City _____ State_____ Zip_____

Your Home # _____ Work #_____ Cell #_____

2. THE USE AND / OR DISCLOSURE AUTHORIZED

Mark the type of health information you are authorizing to be used are disclosed.

1. Treatment Plan _____
2. Medications _____
3. Diagnosis _____
4. Personal Information Discussed _____
5. Other _____

Name the people and / or organizations that you are authorizing to use and / or disclose your protected health information

1. Spouse _____
   (Last) (First)
2. Children _____
   (Last) (First)
3. Friends _____
4. Other Family Members _____
   (Last) (First)
5. Pharmacy _____
   (Name of Pharmacy)
6. Physicians _____ _____
   (Name of Physicians)

The purpose for which I am authorizing the release of information is:

(The purpose is the reason you are authorizing the release of information (i.e., medical benefit, medical appeal, etc.) *If you do not wish to specify a reason for the release of information, you must select the 'My Request' field.)*

_____ My request *or* Other *(please describe)*: _____

Sign and Date This Form

_____ _____
Signature **Print Name**

_____/_____/_____ _____
Date of Signature (MM/DD/YYYY) **Relationship to Member**

Patient History for Dr. Dunn's Office

Name:_____ Today's Date: _____

Date of Birth: _____ Age: _____

Primary care Physician: _____ Referring Physician: _____

Current Health
Please Complete All Information

Reason for Visit Today: _____

Are you currently on a blood thinner: **YES / NO** **Medication?** _____

Do you have any medical problems?

Please list them: _____

_____

Previous surgeries: _____

_____

Drug sensitivity and allergies: _____

Do you currently take any aspirin or arthritis medication?

Please list them: _____

Do you use tobacco? **YES / NO** Do you use alcoholic beverages? **YES / NO**

Family History

Do you have a family history of Colon Polyps or Colon Cancer: **YES / NO / BOTH**

If so, please specify: _____

Clarence Butch Dunn, Jr., M.D.

(A Professional Medical Corporation)
Board Certified
Gastrointestinal Specialist

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West Monroe, LA 71291

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date Of Birth: _____ Age: _____

Email

Personal: _____

Contact Preference

- ◯ Email
- ◯ No preference
- ◯ Phone or letter
- ◯ Portal
- ◯ Patient declines to specify

Race

Select one or more

- ◯ White
- ◯ Black or African American
- ◯ Asian
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Other Race
- ◯ Unknown
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to specify
- ◯ Prohibited by state law
- ◯ Unknown

Sex

- ◯ Male
- ◯ Female
- ◯ Other
- ◯ Unknown

Preferred Language

- ◯ English
- ◯ Spanish; Castilian
- ◯ Patient declines to specify

Review Of Systems

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○
anemia	○	○
irritable bowel disorder	○	○
gerd	○	○
reflux	○	○
elevated liver functions	○	○

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
irregular heart beat	○	○
palpitations	○	○
peripheral edema	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○
rigors	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
panic attacks	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
wheezing	○	○

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Latex
- ☐ Eggs
- ☐ Soy
- ☐ Peanuts
- ☐ Sulfa
- ☐ Penicillins
- ☐ codeine sulfate
- ☐ Cephalosporins
- ☐ Erythromycin
- Other: _____

Pharmacy

Name | Address | Phone

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- ☐ Yes
- ☐ No

Current Medications

- ☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Influenza, seasonal, injectable	☐ Hep B	☐ Hep A	☐ tetanus toxoid	☐ Pneumonia
	When: _____	When: _____	When: _____	When: _____

When: _____

Past or Present Medical Conditions

☐ None

GASTROINTESTINAL (UPPER GI)	☐ Acid Reflux	☐ Anemia	☐ Barrett's esophagus	☐ Celiac disease (sprue)
	☐ Delayed gastric emptying	☐ Dysphagia	☐ Gallstones	☐ Helicobacter Pylori
	☐ Hiatal hernia	☐ Stomach cancer	☐ Stomach ulcers	Other: _____
GASTROINTESTINAL (LOWER GI)	☐ Colon cancer	☐ Colon polyp(s)	☐ Crohn's disease	☐ Diverticulitis
	☐ Diverticulosis	☐ Irritable bowel syndrome	☐ Ulcerative colitis	Other: _____
GASTROINTESTINAL (BILIARY)	☐ Cirrhosis	☐ Fatty liver	☐ Hepatitis A	☐ Hepatitis B
	☐ Hepatitis C	☐ Abnormal liver tests	☐ Pancreatitis	Other: _____
CARDIOVASCULAR	☐ Atrial fibrillation	☐ Blood clots (DVT)	☐ Congestive heart failure	☐ Coronary artery disease
	☐ Dyspnea with exercise	☐ Endocarditis	☐ Heart attack	☐ High blood pressure
	☐ Mitral valve prolapse	☐ Stroke	☐ TIA	Other: _____
PULMONARY	☐ Asthma	☐ COPD	☐ Emphysema	☐ Sleep apnea
	Other: _____			
OTHER:	☐ Anxiety disorder	☐ Arthritis	☐ Chronic back pain	☐ Dementia
	☐ Diabetes mellitus	☐ Glaucoma	☐ HIV	☐ Renal insufficiency
	☐ Sickle cell trait	☐ Seizures	☐ Cancer: _____(type)	Other: _____

Diagnostic Studies/Tests

☐ None

GI ENDOSCOPY	☐ Bravo PH monitor	☐ Capsule endoscopy	☐ Colonoscopy	☐ Double balloon endoscopy
	☐ EGD	☐ ERCP	☐ Esophageal dilation	☐ Esophageal manometry
	☐ Flexible sigmoidoscopy	☐ PEG (feeding) tube	Other: _____	
RADIOLOGY EXAMS	☐ CT scan	☐ Gastric emptying scan	☐ Hida scan w/ cck	☐ Liver biopsy
	☐ MRI	☐ MRCP	☐ Small bowel series	☐ Ultrasound
	Other: _____			

Previous Procedures

☐ None

SURGICAL PROCEDURES:

☐ Appendectomy	☐ Bladder suspension	☐ C Section	☐ Cardiac bypass
☐ Cardiac stent(s)	☐ Colectomy (partial)	☐ Colectomy (total)	☐ Colostomy
☐ Defibrillator	☐ Gallbladder removal	☐ Gastric bypass	☐ Hemorrhoid sur
☐ Hysterectomy	☐ Lap band-Gastric sleeve	☐ Mastectomy	☐ Pacemaker
☐ Prostate surgery	☐ Reflux surgery	☐ Small bowel resection	☐ Whipple procedure
☐ Valve replacement	Other: _____		

Social History

Occupation: _____ Number of Children: _____

Marital Status

☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed
☐ Civil Union	☐ Unknown	☐ Other		

Alcohol

☐ None

Type	Quantity	Frequency
☐ Beer		
☐ Wine		
☐ Liquor		

Tobacco

Smoking Status

☐ Current every day smoker	☐ Current some day smoker	☐ Former smoker	☐ Never smoker
☐ Smoker, current status unknown	☐ Light tobacco smoker	☐ Heavy tobacco smoker	☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Smokeless				
☐ Chewing Tobacco				
☐ Other				

Drug Use

☐ None

Type	Quantity	Frequency
☐ Uses IV drugs currently		
☐ Used IV drugs in the past		
☐ Recreational drug use		

Family Medical History

○ No knowledge of family history

No family history of

○ Celiac Disease
○ Chronic liver disease
○ Colon Cancer
○ Colon Polyps
○ Ulcerative Colitis/Crohn's Disease

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son
Family history of colon cancer	○	○	○	○	○	○
Family history of colon polyps	○	○	○	○	○	○
Family history of Celiac disease	○	○	○	○	○	○
Family history of Colitis/Crohn's Disease	○	○	○	○	○	○
Family history of Liver Disease	○	○	○	○	○	○

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities that are involved in my care.

○ Yes ○ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

○ Yes ○ No

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present