



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, checks, and CareCredit.** 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 **forty-eight (48) hour notice** policy for procedures and the **twenty-four (24) hour notice** policy for appointments. **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 below, 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

302 McMillan Road  
West Monroe, LA 71291

Phone: 318-322-2202  
Fax : 318-322-9949

## 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

<input type="radio"/> None	Y	N
abdominal pain	<input type="radio"/>	<input type="radio"/>
abdominal swelling	<input type="radio"/>	<input type="radio"/>
change in bowel habits	<input type="radio"/>	<input type="radio"/>
constipation	<input type="radio"/>	<input type="radio"/>
diarrhea	<input type="radio"/>	<input type="radio"/>
gas	<input type="radio"/>	<input type="radio"/>
heartburn	<input type="radio"/>	<input type="radio"/>
jaundice	<input type="radio"/>	<input type="radio"/>
nausea	<input type="radio"/>	<input type="radio"/>
rectal bleeding	<input type="radio"/>	<input type="radio"/>
stomach cramps	<input type="radio"/>	<input type="radio"/>
vomiting	<input type="radio"/>	<input type="radio"/>
difficulty swallowing	<input type="radio"/>	<input type="radio"/>
anemia	<input type="radio"/>	<input type="radio"/>
irritable bowel disorder	<input type="radio"/>	<input type="radio"/>
gerd	<input type="radio"/>	<input type="radio"/>
reflux	<input type="radio"/>	<input type="radio"/>
elevated liver functions	<input type="radio"/>	<input type="radio"/>

## Allergic/Immunologic

<input type="radio"/> None	Y	N
HIV exposure	<input type="radio"/>	<input type="radio"/>
persistent infections	<input type="radio"/>	<input type="radio"/>
strong allergic reactions or urticaria	<input type="radio"/>	<input type="radio"/>

## Cardiovascular

<input type="radio"/> None	Y	N
chest pain	<input type="radio"/>	<input type="radio"/>
irregular heart beat	<input type="radio"/>	<input type="radio"/>
palpitations	<input type="radio"/>	<input type="radio"/>
peripheral edema	<input type="radio"/>	<input type="radio"/>

## Constitutional

<input type="radio"/> None	Y	N
fatigue	<input type="radio"/>	<input type="radio"/>
fever	<input type="radio"/>	<input type="radio"/>
loss of appetite	<input type="radio"/>	<input type="radio"/>
malaise	<input type="radio"/>	<input type="radio"/>
sweats	<input type="radio"/>	<input type="radio"/>
weight gain	<input type="radio"/>	<input type="radio"/>
weight loss	<input type="radio"/>	<input type="radio"/>
rigors	<input type="radio"/>	<input type="radio"/>

## Psychiatric

<input type="radio"/> None	Y	N
anxiety	<input type="radio"/>	<input type="radio"/>
depression	<input type="radio"/>	<input type="radio"/>
difficulty sleeping	<input type="radio"/>	<input type="radio"/>
panic attacks	<input type="radio"/>	<input type="radio"/>

## Respiratory

<input type="radio"/> None	Y	N
asthma	<input type="radio"/>	<input type="radio"/>
cough	<input type="radio"/>	<input type="radio"/>
dyspnea	<input type="radio"/>	<input type="radio"/>
excessive sputum	<input type="radio"/>	<input type="radio"/>
wheezing	<input type="radio"/>	<input type="radio"/>



## Immunizations

None

Influenza, seasonal, injectable

Hep B

When: \_\_\_\_\_

Hep A

When: \_\_\_\_\_

tetanus toxoid

When: \_\_\_\_\_

Pneumonia

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:

Other: \_\_\_\_\_

\_\_\_\_\_ (type)

## 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
<input type="radio"/> Beer	_____	_____
<input type="radio"/> Wine	_____	_____
<input type="radio"/> 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
<input type="radio"/> Cigarettes	_____	_____	_____	_____
<input type="radio"/> Smokeless	_____	_____	_____	_____
<input type="radio"/> Chewing Tobacco	_____	_____	_____	_____
<input type="radio"/> Other	_____	_____	_____	_____

### Drug Use

None

Type	Quantity	Frequency
<input type="radio"/> Uses IV drugs currently	_____	_____
<input type="radio"/> Used IV drugs in the past	_____	_____
<input type="radio"/> Recreational drug use	_____	_____

## Family Medical History

---

No knowledge of family history

No family history of

<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Chronic liver disease
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Colon Polyps
<input type="checkbox"/> Ulcerative Colitis/Crohn's Disease	

---

Mother  
Father  
Sister  
Brother  
Daughter  
Son

## Diagnoses

---

Family history of colon cancer	<input type="checkbox"/>					
Family history of colon polyps	<input type="checkbox"/>					
Family history of Celiac disease	<input type="checkbox"/>					
Family history of Colitis/Crohn's Disease	<input type="checkbox"/>					
Family history of Liver Disease	<input type="checkbox"/>					

## 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