GREAT LAKES GASTROENTEROLOGY

powered by OneGI

*****PLEASE FILL OUT ENTIRE FORM*****

Patient's Name: _____ TODAY'S DATE: _____

Date of Birth (DOB):_____ Current Age:_____ Sex: ☐ MALE ☐ FEMALE

Address:_____ City, State & Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed SSN: _____- _____ - _____

Family Doctor/PCP:_____

Referring Doctor: _____

Pharmacy:_____

Mail Order Pharmacy:_____

May we leave a message: On your voicemail/answering machine ☐ No ☐ Yes Via Text Message: ☐ No ☐ Yes

Via Email ☐ No ☐ Yes If yes, email address: _____

Employer / School:_____

WHO CAN WE SPEAK TO REGARDING YOUR MEDICAL CONCERNS / HISTORY?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

EMERGENCY CONTACT: (phone # must be different than patient's phone #)

Name: _____ Phone #: _____ Relationship: _____

Responsible Party for Insurance & Medical Bills: ☐ Patient ☐ Spouse ☐ Parents ☐ Mother ☐ Father ☐ Other

Primary Insurance Company:_____

Subscriber Name:_____ Subscriber DOB:_____

Insurance ID #:_____ Insurance Group # :_____

Relationship to Card Holder: ☐ Self ☐ Spouse ☐ Dependent Card Copied: ☐ YES ☐ NO Co-Payment: $_____

Secondary Insurance Company: _____

Subscriber Name:_____ Subscriber DOB: _____

Insurance ID #: _____ Insurance Group #:_____

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Please fill out the information found below to the best of your ability.

Date of Birth _____ Physician _____ Today's Date _____

Patient Name _____

Patient Medical History

Have you ever had the following? (Check no, yes, or leave blank if uncertain.)

Anemia	☐ No	☐ Yes	Dementia	☐ No	☐ Yes	Irritable Bowel Syndrome	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes	Depression	☐ No	☐ Yes	Kidney Renal Disease	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Kidney Stones	☐ No	☐ Yes
Asthma	☐ No	☐ Yes	Diverticulitis	☐ No	☐ Yes	Migraines/Headaches	☐ No	☐ Yes
Barretts Esophagus	☐ No	☐ Yes	Fatty Liver	☐ No	☐ Yes	Parkinson's Disease	☐ No	☐ Yes
Cancer	☐ No	☐ Yes						
If yes, what kind/ Date? _____			Fibromyalgia	☐ No	☐ Yes	Reflux (GERD)	☐ No	☐ Yes
Celiac	☐ No	☐ Yes	Gallstones	☐ No	☐ Yes	Seizure Disorder	☐ No	☐ Yes
Cirrhosis	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Sleep Apnea (CPAP)	☐ No	☐ Yes
Colitis	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Colon Polyps	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
			If yes, Type? _____			OTHER		
Crohn's	☐ No	☐ Yes	Hernia	☐ No	☐ Yes			
			If yes, Type? _____			Please list other: _____		
Congestive Heath Failure	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	_____		
COPD or Emphysema	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes	_____		
Coronary Artery Disease	☐ No	☐ Yes	HIV	☐ No	☐ Yes	_____		
Pacemaker	☐ No	☐ Yes	Defibrillator	☐ No	☐ Yes			
Home Oxygen Use	☐ Day	☐ Night	Liters _____					

Specialist: Cardiologist _____ Pulmonologist _____ Nephrologist _____

Surgical History

Check if none	☐ None	Heart Stents/ Date: _____	☐ Yes	Mastectomy (Breast) Surgery	☐ Yes
Appendix Removal	☐ Yes	Heart Surgery/Bypass	☐ Yes	Date: _____	
Back Surgery	☐ Yes	Heart Valve Replacement, Aortic	☐ Yes	MOH (skin cancer procedure)	☐ Yes
Blood Transfusion	☐ Yes	Heart Valve Replacement, Mitral	☐ Yes	Pacemaker (date last checked) _____	☐ Yes
Colectomy	☐ Yes	Hernia repair	☐ Yes	Prostate	☐ Yes
Partial Colectomy	☐ Yes	Hiatal Hernia Surgery	☐ Yes	Small Bowel Resection	☐ Yes
Colostomy	☐ Yes	Hysterectomy	☐ Yes	Tonsillectomy	☐ Yes
Ileostomy	☐ Yes	ICD(Internal Cardiac Defibrillator)	☐ Yes	Adenoidectomy	☐ Yes
C-Section	☐ Yes	Hip Replacement	☐ Yes	Wisdom Teeth	☐ Yes
G Tube	☐ Yes	Knee Replacement	☐ Yes	Thyroidectomy	☐ Yes
J Tube	☐ Yes	Shoulder Replacement	☐ Yes	Transplant	☐ Yes
Gallbladder Surgery	☐ Yes	Joint Surgery	☐ Yes	Any Anesthesia issues? _____	
Duodenal Switch	☐ Yes	Laparoscopy	☐ Yes	History of difficult Intubation? _____	
Gastric Sleeve	☐ Yes	Liver Biopsy	☐ Yes	Metal or Plastic Implants & where _____	
Roux en Y	☐ Yes	Lung Surgery	☐ Yes		

Patient Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Number of Children: _____

Alcohol Use: ☐ Never ☐ Occasionally – Drinks per Week _____ ☐ Daily – Drinks per Day _____
Tobacco Use: ☐ Never ☐ Previously, but Quit – Packs per Day _____ ☐ Currently – Packs per Day _____
Recreational Drug Use: ☐ No ☐ Yes, Type & Frequency _____

Patient Name & DOB: _____ **Today's Date:** _____

Family Medical History- If yes, list Relation and Age:

Celiac: _____
Colon Cancer: _____
Colon Polyps: _____
Inflammatory Bowel Disease: _____
Cancer of:
Endometrial: _____
Esophagus: _____
Kidney: _____
Ovarian: _____
Pancreas: _____
Small Bowel: _____
Stomach: _____

Please list all prescribed medications, including vitamins, over-the-counter, and as needed

MEDICATION	DOSE	HOW MANY TIMES PER DAY	REASON

Allergies, Sensitivities, Reactions: **Check if none:** ☐

Patient Name & DOB: _____ **Today's Date:** _____

Review of Systems: Please indicate any personal history below.

GASTROINTESTINAL	YES	NO
Nausea		
Vomiting		
Heartburn		
Food stuck in throat		
Painful Swallowing		
Vomiting Blood		
Black Stool		
Red blood in stool		
Abdominal Pain		
Constipation		
Loss of Appetite		
Early satiety		
Bloating		
Hemorrhoids		

CONSTITUTIONAL	YES	NO
Recent Weight Gain		
How much?		
Recent Weight Loss		
How much?		

HEENT	YES	NO
Sore Throat		
Hoarseness		

CARDIOVASCULAR	YES	NO
Abnormal Heart rhythm		
Chest Pain		
Palpitations		

RESPIRATORY	YES	NO
Cough		
Shortness of Breath on Exertion		
Shortness of Breath at rest		
Wheezing		

GENITOURINARY	YES	NO
Frequent Urination		
Kidney failure/dialysis		
Painful Urination		

NEUROLOGICAL	YES	NO
Seizures		
Headaches		

DERMATOLOGY	YES	NO
Rash		

MUSCULOSKELETAL	YES	NO
Joint Pain		
Arthritis		

PSYCHIATRIC	YES	NO
Dementia		
Depression		
Anxiety		

Height:
Weight:

When / Where was your last upper endoscopy? _____

When / Where was your last colonoscopy? _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

SIGNATURE: _____ DATE: _____

Patient Financial Statement & Acknowledgement

Thank you for choosing Great Lakes Gastroenterology as your health care provider. Please understand that payment of your bill is considered a part of your treatment. We welcome the opportunity to discuss any aspect of our Financial Policy with you or your legal/authorized representative. Please review the following information as it details your patient financial responsibilities.

INSURANCE:

- Insurance coverage is a contract between you and your insurance company. Patients must understand policy provisions.
- Patients using a private insurance carrier or government sponsored program must present current insurance cards and photo ID prior to services being rendered.
- Great Lake Gastroenterology will file an insurance claim as a courtesy on each patient's behalf, but cannot guarantee payment of claims, accept responsibility for collecting payment or for negotiating settlement on a disputed claim.
    - A reduction or rejection of your claim by the insurance company does not relieve patients of financial obligation.
    - Professional services are rendered and charged to the patient, not the insurance company. Patients are responsible for payment in full on all services rendered.
- Needs for referrals and/or authorization services related to their current appointment must be verified by patients with their insurance plans.
    - Appointments will be rescheduled should a referral and/or authorization not be obtained prior to the patient's appointment date.
- If a patient's insurance company pays only a portion of the bill or rejects the claim, any contact or explanation should be made to the patient who is the policyholder.
    - Not all services are a covered benefit in all insurance plans.

COPAYMENTS, DEDUCTIBLES & NON-COVERED SERVICES:

- All copayments, deductibles, and payment for non-covered services are due at the time services are rendered.
    - Please bring a method of payment in preparation for your appointment.
    - Great Lakes Gastroenterology does not wave copayments, deductibles, or other patient balances.
- If Great Lakes Gastroenterology does not participate with a patient's insurance plan or if the patient does not have health insurance coverage, payment in full is due at the time all services are rendered.
    - If a patient is unable to pay required co-pay, deductible or any self-pay fees, the appointment may be rescheduled.

COMMUNICATION:

- Communication regarding a patient's account may be necessary to ensure the account remains in good standing.
- The undersigned provides authorization to receive communication regarding his/her account from Great Lakes Gastroenterology, its affiliates, and/or business partners through multiple methods to include, but not limited to, postal mail, voice call, call via auto-dialer, pre-recorded voice messages, SMS messages, and email to any landline phone, cell phone, or email address provided.

NON-PAYMENT & ACCOUNTS REFERRED TO COLLECTIONS:

- If a patient account becomes delinquent and the patient has not responded to our collection efforts, the account will be turned over to an outside source for collecting the full balance due:
    - Patient will be responsible for all additional fees related to that expense (i.e., applicable court costs and legal fees).
    - These fees will be in addition to the any existing overdue balance.
    - We encourage patients to contact our billing team at 440-205-1225 for payment assistance.
    - A patient's failure to pay off a balance or to initiate a payment plan may lead to the patient's dismissal from the practice.

RETURNED CHECKS:

- All returned checks are subject to a service fee.
- Returned check fee(s) must be paid in full prior to scheduling future appointments.

MISSED APPOINTMENTS:
Great Lakes is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

OFFICE TELEHEALTH APPOINTMENTS:

- Patients unable to keep a scheduled office or telehealth appointment must notify us at least 24 hours in advance to cancel and/or reschedule the appointment. This notification allows us time to offer another patient an opportunity to be seen.
- Patients must make every effort to be on time for appointments and to arrive early to complete any necessary paperwork.
- **A $50.00 fee will be incurred for office/telehealth appointments not cancelled and/or rescheduled at least by 2pm the day prior to your scheduled appointment. To cancel your Monday appointment, please call by 2pm on Friday.**
- After you have had 3 late notice cancelations or no-shows, you may be discharged from the practice.

PROCEDURE APPOINTMENTS:

- **Procedure appointments not cancelled or rescheduled at least 72 hours in advance will incur a $250.00 charge.**
- Cancellation charges are not covered or paid by any insurance company and will be billed directly to the patient.
    - All cancellation fee(s) must be paid in full prior to scheduling future appointments.
- **If you No Show for your scheduled procedure, you will need to pay the $250.00 charge, along with having to see your physician in the office or by telehealth prior to rescheduling your procedure.** If you No Show for more than one procedure, you may be discharged from the practice.

AFFILIATIONS:

- Great Lakes Gastroenterology is affiliated with Dayton Gastroenterology. You may see this business name on your insurance Explanation of Benefits.
- Patients may receive statements from multiple entities after having a procedure.
- Although the physicians of Great Lakes Gastroenterology may have shareholder interest in external procedure centers, patients may receive separate statements for fees associated with professional services, facility, pathology, infusion services, or other diagnostic testing.
- If a patient has a procedure performed by any of our physicians at an ambulatory surgical center or a hospital, the patient will receive a bill from that facility for its facility fee as well as from Great Lakes Gastroenterology for applicable professional and ancillary services.

PATIENT ACKNOWLEDGEMENT:
I have received, reviewed, and understand the Great Lakes Gastroenterology financial policy and I agree to be bound by each of its terms and conditions. I also understand and agree that such terms may be amended by the practice from time to time. I understand that I am financially responsible for all charges regardless of payments made by my insurance. I hereby authorize Great Lakes Gastroenterology to release medical information to my insurance company to secure payment of benefits. I also authorize the use of this signature on all insurance submissions and as authorization for payments to be sent to Great Lakes Gastroenterology. This signature authorizes release of medical records to any physicians or health care facility when referred or requested by them for continuity of care. I voluntarily consent to medical care including the routing of diagnostic testing, surgical procedures, and additional medical treatment.

PATIENT NAME (Please Print) **DATE OF BIRTH**

PATIENT SIGNATURE (or Responsible Party & Relationship) **DATE**

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Privacy Consent – For the Use & Disclosure of Protected Health Information (PHI)

This consent is required by the Health Insurance Portability & Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to DDC and the Endoscopy Center of Northern Ohio to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment, or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives it.

Patient / Guardian Signature: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

Copy of Practice Privacy statement signed or initiated with patient / guardian on: _____

Patient unable to sign privacy statement due to: _____

REVOCATION

I hereby revoke the consent given above:

Patient / Guardian Signature: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance company may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Patient / Guardian Initials: _____ Date: _____