Welcome to Southern Gastroenterology Specialists, PC

Dear Patient:

An appointment has been scheduled for you on _____

with Doctor_____at

1502 West Third Street

Jackson, GA 30233

Adjacent to Eagles Landing Family Practice. The suite is located between Atlanta Heart and Urology Practice.

Please arrive for your appointment at_____am/pm.

Your appointment is scheduled at_____am/pm.

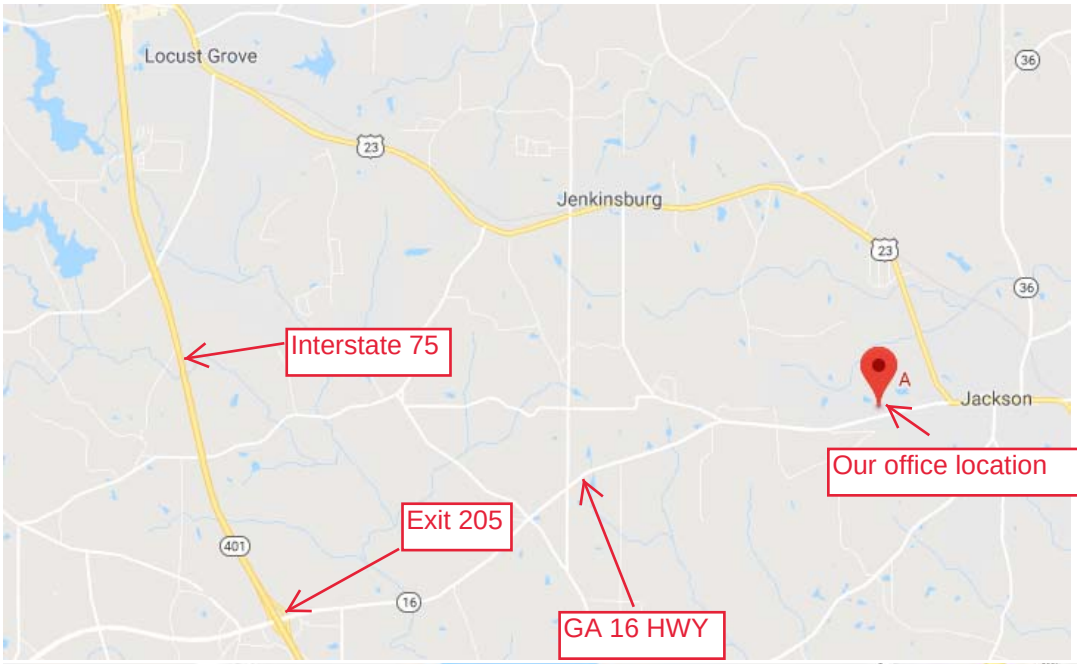
In an effort to make the registration process more efficient, please bring the following items to your appointment:

- Completed SGS GI History Form (enclosed). This form contains valuable information and will assist the doctor in your care.
- Your insurance card(s) and photo ID.
- A list of your medications (to include prescription and over-the-counter), vitamins, supplements and herbs along with the dosage, and how often you take them.
- SGS Financial Policy (enclosed). It is important to us that you understand our policy so please read this carefully and if you have questions, do not hesitate to ask.
- Co-pay is expected to be paid at the time of service.

Again we would like to welcome you to Southern Gastroenterology Specialists.

Sincerely,

Southern Gastroenterology Specialists, PC


Locust Grove
Jenkinsburg
Jackson
A
Interstate 75
Our office location
Exit 205
GA 16 HWY
23
36
401
16


Ingles Market
A
W 3rd St
April Ln
West Ave
Old Griffin Rd
Cedar St
16

Demographics Verification Form

DEMOGRAPHIC INFORMATION			
Patient Name:		Chart ID:	
Mailing Address:			
City:	State:	Zip:	County:
Home Phone:	Cell Phone:		Work Phone:
Date of Birth:	Sex:		Marital Status:
Social Security Number:			
Employer Name:			
Employer Address:			
Primary Care Provider:	REFERRING DOCTOR:		
Email:			
Select One: White____ Black/African Amer____ Hispanic____ Other _____ Language spoken:			
OK to Leave Message: Home Cell Brief Extended			

EMERGENCY CONTACT INFORMATION	
Emergency Contact Name:	
Phone Number:	
Relationship to Patient:	☐ HIPAA

PRIMARY INSURANCE INFORMATION	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber Number:	
Subscriber Address:	
Group Number:	
Insured's Rel to Pt:	

SECONDARY INSURANCE INFORMATION	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber Number:	
Subscriber Address:	
Group Number:	
Insured's Rel To Pt:	

PHARMACY INFORMATION
Pharmacy Name/Location:
Pharmacy Number:
Alternate Pharmacy Name/Location/Phone:

I attest that the above information is correct and have read and understand the policies of Southern Gastroenterology Specialists, and accept my responsibility as stated in those policies. I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge.

I hereby allow the clinical staff of Southern Gastroenterology Specialists to view my medication history from external sources.

Patient Signature DATE

PATIENT HISTORY FORMS

HISTORY INFORMATION

Patient Name:	**Chart ID:**

Who referred you to our office:

Have you been seen by any of our providers:(circle one) Yes / No

If so what year: _____

Chief Complaints: Reasons for visist today (circle all that apply)

Abdominal pain	Difficulty Swallowing	Change in bowel habits
Nausea/Vomiting	Abnormal liver test	Colon Cancer Screening
Constipation	Diarrhea(rarely/often)	Pain/trouble with swallowing
Gerd(acid reflux)	Blood in stool/on toilet tissue	Liver Diease

Current medications:

NAME	MG	# x OF DAY
1		
2		
3		
4		
5		
6		
7		
8		

Medical History

Cardiac: (circle all that apply)

High Blood Pressure	When:	Blood Clots	When:
Heart Murmur		Aneurysm	When:
High Cholesterol		Heart Attack	When:
Pacemaker		Defibrillator	
Peripheral Vascular Disease		Coronary Art	
Irregular Heart Beat			

Please list any other heart conditions you have: _____

Blood thinners:(circle) Yes or NO Name:

Do you have a History of a coronary stent placement or bypass: Yes / No

Cardiologist Name: _____ **Phone:** **Fax:**

Why do you see them: _____

Last seen: _____

PATIENT HISTORY FORMS

Patient Name:	Chart ID:

Respiratory (circle all that apply)

Asthma	Pulmonary embolism	Pulmonary fibrosis
COPD	Sleep Apnea	Do you use CPAP Yes / No

Neurology (circle all that apply)

Dementia/Alzheimer's	Seizure Disorder When:
Mirgraines	Stroke When:

Spinal cord injury (eg permanent loss of sensation, paralysis, ect

Musculoskeletal (circle all that apply)

Arthritis	Rheumatoid Arthritis
Degenerative disk Disease	Degenerative Joint Disease

Renal/Endocrine (circle all that apply)

Thyroid Disease:	Hyperthyroidism	Kidney Disease
	Hypothyroidism	Diabetes (Type 1 or 2)
Dialysis	Peritoneal	
	Hemodialysis	

GASTROINTESTINAL (circle all that apply)

Crohn's Disease	Cirrhosis
Hepatitis	Ulcerative Colitis
Hepatitis B	Ulcer Where:
Hepatitis C	Colon Polyps
Liver Disease	

BLOOD DISORDERS (circle all that apply)

Anemia	HIV Positive	AIDS
Hemochromatosis (g6pd)	Bleeding disorder	If so what type:
Definciency YES / NO		

Please list any other blood disorders:

MENTAL DISORDERS (circle all that apply)

Depression	Anxiety
Schizophrenia	Bipolar Disorder

Please list any other mental disorders:

PATIENT HISTORY FORMS

Patient Name:	Chart ID:

OTHER (circle all that apply)

Pregnant — How many weeks? _____ Hearing impairment

Breasting feeding — **Yes / No**

Glaucoma — **Diagnosed?** _____

Cancer — **Diagnosed?** _____

What type? _____

(Ex. Colon Pancreatic, Liver, Stomach)

Other, please specify where: _____

Please list any other disorders: _____

ALLERGIES (LIST ALL)

1	6
2	7
3	8
4	9
5	10

SURGICAL HISTORY

Other Past testing or surgies:	**YES / NO**	When/ Where
Have you ever have a colonoscopy	**YES / NO**	When/ Where
Ever had an upper endoscopy/EGD	**YES / NO**	When/ Where
Have you had any recent labs	**YES / NO**	When/ Where
Imaging (U/S, MRI, CT)	**YES / NO**	When/ Where

FAMILY HISTORY (IMMEDIATE FAMILY)

	Living		Medical History
MOTHER	YES /NO		
FATHER	YES /NO		
SISTERS	YES /NO	HOW MANY:	
BROTHERS	YES /NO	HOW MANY:	
CHILDERN	YES /NO	HOW MANY:	

COLON CANCER	AGE:	RELATIONSHIP:
CANCER	AGE:	RELATIONSHIP:
	Where did it start?	
COLON POLYPS	YES / NO	RELATIONSHIP:
HEART DISEASE	YES / NO	RELATIONSHIP:

PATIENT HISTORY FORMS

Patient Name:	Chart ID:

SOCIAL HISTORY (circle all that apply)

Marital Status Single / Married / Divorced / Widowed /Other

Occupation: _____

Do you smoke: Yes / No / Quit (what year): _____

How long: _____ **How much:** _____

Do you drink:

Yes / No / Quit (what year):

How long: _____ **How much:** _____

Do you have a history of alcohol abuse in the past : Yes / No

Do you have a history of drug use, if so when and what type of drugs: _____

Do you have Advance Directives: Yes / No

Do you want us to help you make an Advance Directive: If yes, please let us know. (living will) _____

Signature of Patient **Date**

PATIENT HISTORY FORMS

Patient Name:	Chart ID:

NURSES USE ONLY:

VITALS

Temp: _____

Blood pressure: _____

Weight: _____

Height: _____

Pulse: _____

Record by circling the appropriate option: Document flu shot status in review of system-last item

BMI: **NORMAL / HIGH** **IF BMI OVER 50 OR ABOVE, SCHEDULE PROCEDURE AT THE HOSPITAL**

SMOKER: **YES / NO**

FLU SHOT:

TAKEN:

WHEN: _____

NOT TAKEN, BUT WANTS TO TAKE: _____

DOES NOT TAKE IT, WHY: _____

WHEN WAS PATIENTS LAST COLONOSCOPY: _____

NURSE SIGNATURE **Date:**

Authorization for Release/Disclosure of Medical Information

Name of Medicaloffice/Hospital	Name of Medicaloffice/Hospital
Address	Address
Phone Number/Fax Number	Phone Number/Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Patient name	DOB	Phone number
Address	State	Zip

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party.

Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Specify Records to be Released/Disclosed:

(Check which information is to be released/disclosed; If not specified 2 years will be provided by default

☐	General Medical Information (from_____to_____
☐	Information Regarding Specific Injury or Treatment (from_____to_____)
☐	X-Ray (check one or both): { } Films { } Reports
☐	Laboratory Results
☐	Mental Health (from_____to_____)
☐	Alcohol/Drug (from_____to_____)
☐	HIV Test Results (from_____to_____)
☐	Other (specify):

I request that the health information released/disclosed pursuant to this authorization be used for the following purposes only: Review of Medical Records

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization

Patient Signature	**Date**

SOUTHERN GASTROENTEROLOGY SPECIALISTS, PC

FINANCIAL POLICY

We, the staff of **Southern Gastroenterology Specialists** thank you for choosing us as your specialists care provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with a high level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship, and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact the office and speak with a staff member.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff in writing.

We make payment as convenient as possible by accepting cash, debit card, credit card or check. A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to set up an automatic debit payment plan for your convenience knowing that the security of your information is important to us.

If financial agreements or medical necessities are not kept in good faith, you will be notified by regular or certified mail that you have 30 days to find alternative medical care

If your account is placed with an outside collection agency, you will be charged the full amount of collection fees, attorney fees and allowable court costs. Please note that placement with an outside agency may cause us to terminate your care with our office.

Initials_____

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you try to receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier. This is a contractual agreement between you and your insurance carrier. Your insurance company will determine what amount, if any, you owe to **Southern Gastroenterology Specialists**. Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If there is a balance due on your account, we will mail a detailed statement which is due upon receipt. **Do not assume that any statement you receive will be paid by your insurance company.**

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of- network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Initials_____

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, work, or extracurricular activities, there will be an administrative fee, not to exceed $45.00, for the additional information.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, a missed appointment fee may apply. These fees are typically $30.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information, and we follow applicable Federal and State regulations to provide patients with these rights, including as set forth in the Health Insurance Portability and Accountability Act (HIPAA). As permitted by HIPAA, our medical record fees are a reasonable cost-based fee for copies, including the copying, supplies, labor, and postage of the files, and or summaries. We realize that temporary financial problems may affect timely payment of your account. If this should occur, please let us know and contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Treatment

Patients are entitled to be directly involved in their treatment plans. Testing, referrals, medications, and any other treatment ordered during your visit will be listed on the patient's visit summary provided at the end of the visit.

We may provide a paper copy and may post an electronic copy to your Patient Portal. Our providers treat patients based on medical necessity and not on insurance coverage. It is the patient's responsibility to know your benefits and coverage. We will obtain any prior authorizations required by your insurance carrier; however, this does not guarantee payment and does not define patient responsibility amounts.

Initials_____

I have read and understand the above financial policy. I agree to assign insurance benefits to **Southern Gastroenterology Specialists** whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Printed Name of Patient: _____

Signature of Patient or Authorized Representative: _____

Patient: _____ Date: _____

Patient Bill of Rights

The purpose of this policy is to establish guidelines for patient's rights. Copies of the Bill of Rights shall be available to all patients or responsible party upon admission and shall be displayed prominently in the waiting area. Copies of the Bill of Rights shall be available upon request.

POLICY:

I. Patient has the right to respectful care given by competent personnel.

2. A Patient has the right, upon request, to be given the name of his attending practitioners,the names of all other practitioners directly participating in his care, and the names and functions of other health care persons having direct contact with the patient.

3. A Patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation examination, treatment, and medical records are considered confidential and shall be handled discreetly.

4. A Patient has the right to confidential disclosures and records of his medical care except as otherwise provided by law or third party contractual arrangement.

5. A Patient has the right to participation in decisions involving his health care except when such participation is contraindicated for medical reasons.

6. A Patient has the right to know what Center rules and regulations apply to his conduct as a patient.

7. The Patient has the right to expect emergency procedures to be implemented without unnecessary delay.

8. The Patient has the right to good quality care and high professional standards that are continually maintained and reviewed

9. The Patient has the right to full information, in layman's terms, concerning diagnosis, evaluation, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the person designated by the patient or to a legally authorized person.

10. Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of a procedure.

ll. If the patient is unable to give consent, a legally authorized person has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program. The patient or responsible person shall give informed consent prior to participation in the program. The patient or responsible person may refuse to continue in a program to which he has previously given informed consent.

12. A Patient has the right to refuse drugs or procedures, to the extent permitted by status. A practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.

13. A Patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment.

14. The Patient who does not speak English shall have access, where possible, to an interpreter or services to interpret for the patient would be available like language line etc.

15. The Centers shall provide the patient, or patient designees, upon request, access to the information contained in his medical records,unless the attending practitioner for medical reasons specifically restricts access.

16. The Patient has the right to expect good management techniques to be implemented within the Center. These techniques shall make use of time for the patient and avoid personal discomfort of the patient.

17. When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.

18. The Patient has the right to examine and receive a detailed explanation of his bill.

19. A Patient has the right to expect that the Center will provide information for continuing health care requirements means for meeting them.

20. The Patient is informed of his/her right to change primary or specialty physician if another qualified physician is available.

21. The Patient is provided with appropriate information regarding the absence of malpractice insurance coverage.

22. A Patient has the right to be informed of his rights at the time of admission.

23. A Patient has the right to review the credentials of the Professionals providing their care.

24. The patient has the right to receive relief from pain.

25. The patient has the right to have access to after hour's care/emergency after leaving the center and such instructions would be provided before the patient leaves the center.

26. The patient has the right to refuse participation in any experimental research activity.

27. The patient privacy- Current IDPAA rules regarding the patient rights would be followed in both the centers.

See the attached brochure developed for all entities including endoscopy centers.

Patient Complaints and Grievances

The Center will receive, investigate and follow up on complaints regarding the quality or appropriateness of services.

PROCEDURE:

A. The Center has a complaint form that may be obtained from the receptionist by any individual who wants to report any questions or concerns that they have with the services provided.

B. The Center, through its Administrator, Medical Staff and GOVERNING BODY will investigate all complaints. Based on the findings, appropriate action will be taken to rectify the problem.

C. The administrator would contact the person with the grievance and inform that person of the investigation and action being taken to address the grievance.

D. A written response will be provided to the individual within 30 days of receipt of the complaint by certified mail to the person filing the the complaint or grievance.

E. The compliant can be filed with the organization by contacting a The administrator at 770-692-0100(W) and 404-641-3345(cell) b. Or by filing a written complaint addressed to the administrator and handing over to the receptionist or Nursing Director c. Or by emailing to: problems@gastromds.net

F. If an individual feels that their complaint was not followed up appropriately, the Georgia Department of Community Health can be notified at : a. 404-657-5728 or 404-657-5726 by speaking to Ms.Sandra Sampson b. Or by filing with www.ors.dhr.ga.gov and the instructions are provided at the site. c. Or filing a complaint with Department of Community Health, , Complaint intake unit, 2 Peachtree Street, NW, Suite 31,Atlanta, GA 30303-3142 in writing.

G. The Medicare web site: http://www.cms.hhs.gov/center/ombudsman.asp

H. Or calling 1-800-Medicare

I. The organization is accredited by AAAHC and ifthere are complaints about the organization they can be sent to AAAHC at the following URL https://www.aaahc.org/en/my-care/Feedback-about-an-accredited-organization/

SIGN

DATE

Notice of HIPAA Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment, including from third-party payers.
- Conduct healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices, including for information held prior to the effective change. I understand that I may request in writing that you restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are generally not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions. I also understand I have the option to pay for a health care service personally and not have such claim submitted to a health plan. To choose this option, I and/or the Patient must notify your Business Office and must pay the bill for that health care service in full.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

To address any special needs you may have and to confirm your wishes, please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one YES NO

If YES, please list names below for our record.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: _____

_____

_____

Staff Initials: _____ Date: _____