



DIGESTIVE HEALTH SPECIALISTS
PATIENT INFORMATION

Name: _____ Date of Birth: _____
First MI Last

Mailing Address: _____
Street City State Zip Code

Please Check One: ☐ Male ☐ Female Social Security Number _____ - _____ - _____

Primary Phone #: _____ May we leave messages on this number? Yes ☐ No ☐

Patient Email: _____

PATIENT CONSENT TO SHARE PERSONAL HEALTH INFORMATION

Please checkmark HIPAA if you would like us to give health information to anyone listed below
HIPAA/Emergency Contacts:

Name: _____ Relationship: _____ Phone#: _____
Emergency ☐ HIPAA ☐

Name: _____ Relationship: _____ Phone#: _____
Emergency ☐ HIPAA ☐

Employer: _____ Work #: _____

Name of Primary Care Physician: _____ Phone#: _____

Address: _____

Insurance Information

Primary Insurance: _____ Policy#: _____ Group#: _____

Claims Address: _____ Phone#: _____

Policy Holder: _____ Date of Birth: _____ Relationship: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

Claims Address: _____ Phone#: _____

Policy Holder: _____ Date of Birth: _____ Relationship: _____

Acknowledgement of review of notice of privacy practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature

Date

Witness

Date

Gastroenterologists:

Susan B. Fleet, MD

Jonathan D. Siegel, MD, FACG

Cody B. Barnett, MD, FACG

251-873-6192 phone

251-873-6193 fax



DIGESTIVE HEALTH SPECIALISTS
OF MOBILE

Gastroenterologists:

Panayiotis Grevenitis, MD

Michael K. Sanders, MD, FASGE

3601 Springhill Business Park Suite 201
Mobile, AL 36608

PHYSICIAN/PATIENT DISCLOSURE FORM

THE PHYSICIAN

During the course of your physician/patient relationship with the physician, the Physician may at a future time refer you to Surgicare of Mobile, LLC, which operates an ambulatory surgery center located at 2890 Dauphin Street, Mobile, AL 36608.

In connection with any such referral, the Physician hereby advises you that the Physician has an invested interest in Surgicare of Mobile and thus in its ambulatory surgery center.

Please be advised that you have the right to obtain the health care items and services for which the Physician refers you at any location or from any ambulatory surgery center, hospital, provider, or supplier of your choice, including Surgicare of Mobile.

I, undersigned patient (the "Patient") received this Physician/Patient Disclosure Form from the above-referenced Physician, and I read and understand the information contained in the Physician/Patient Disclosure Form. The Physician furnished me with this Physician/Patient Disclosure Form prior to the Physician's referral of me to Surgicare of Mobile.

Date: _____

Signature of Patient: _____

Printed Name: _____

Address: _____

Phone: _____

DIGESTIVE HEALTH SPECIALISTS OF THE SOUTHEAST FINANCIAL POLICY

TO OUR PATIENTS:

Thank you for selecting our office for your medical care. In order to prevent any misunderstanding concerning the responsibility for payment for medical or surgical services provided to our patients, the following is supplied:

The patient or the guarantor is responsible for payment for services provided by Digestive Health Specialists of the Southeast at the time of service unless prior arrangements have been made. The only exception is if **Digestive Health Specialists of the Southeast** has contracted with your HMO/PPO insurance plan to accept the insurance payment as payment in full after all deductibles have been met and all co pays have been paid.

We will file a claim to your insurance company for each visit. If requested, we will furnish you with a copy of your bill for each visit, which contains all the information necessary for you to bill any personal reimbursement policies that you may have.

Charges for initial and return office visits will vary depending on the nature of your visit and if any procedures are performed. Additional tests or procedures, such a laboratory, radiology, or other diagnostic tests, will be billed separately by those providers.

HMO/PPO OR CONTRACTED INSURANCE COVERAGE

Certain health insurances (HMO, POS, etc.) require that you obtain a referral from your Primary Care Provider (PCP) or prior authorization from your insurance company before visiting a specialist or having a procedure done. Our team of insurance specialist will assist as a courtesy, but **you are primarily responsible for obtaining all required information.** Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

MEDICAID

If you have Medicaid coverage, we must have your Medicaid card to verify coverage at the time of service and the required co-pay amount. If you have Medicaid coverage pending, we require payment for the services **at the time of your visit.** If, within three months after your visit, you provide a retroactive Medicaid card that covers the date of the visit, we will refund your payment after Medicaid pays for your visit.

MEDICARE

Our physicians are participating Medicare providers. Office visits and procedures by a doctor are covered under part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay your **annual deductible for the calendar year.** If you have supplemental insurance, we require a copy of your insurance card and insurance mailing address.

I have read all the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

In the event that your insurance company is billed, I authorize payment of medical benefits to be paid directly to **Digestive Health Specialists of the Southeast.** A photocopy of this agreement shall be considered as effective and valid as the original.

In the event that my account is placed with a collection agency or an attorney upon default of payment, I agree to pay all collection costs including attorney fees and court costs.

Signature _____

Date _____

Responsible Party _____

Date _____

I authorize the release of any medical information necessary to process my claims.

Signature _____

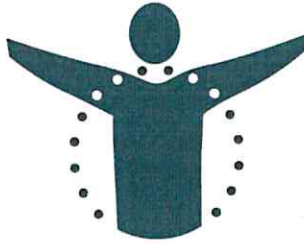
Date _____

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Important Notice

"No Show" Policy

We strive to make every effort to notify you of any upcoming scheduled procedure or upcoming scheduled office appointment by our automated reminder service that calls or sends out text reminders at two different times prior to your scheduled appointment.

We realize there may be times when you need to reschedule your appointment. We ask that you show consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. We would like to have the opportunity to offer that appointment to another patient who needs to see the doctor.

This serves as notice that if you fail to give at least a 24- hour notice of cancellation in the future, there will be a \$50 cancellation fee for a no-show appointment and a \$200 no show fee for procedures.

Repeated missed appointments may result in dismissal from our practice.

I have read and understand the above policy.

Signature

Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release

Healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization apply to:

___ Healthcare information relating to the following treatment, condition, or dates

___ All healthcare information: _____

___ Other: _____

My signature authorizes the release of any records regarding drug, alcohol, or mental health treatment to the person (s) listed above

Patient signature: _____ Date: _____

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Date Of Birth: _____ Age: _____

Email

Personal: _____

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 | ☐ Patient declines to specify |
|-------------------------------|---|

Contact Preference

- | | | | | |
|------------------------------|--------------------------------------|------------------------------|----------------------------------|---|
| ☐ Letter | ☐ Telephone call | ☐ e-mail | ☐ Cell Phone | ☐ Patient declines to specify |
|------------------------------|--------------------------------------|------------------------------|----------------------------------|---|

Other: _____

Reminder Preference

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

- | | |
|---------------------------|--------------------------|
| ☐ Yes | ☐ No |
|---------------------------|--------------------------|

Consent to Share Data

☐ I consent to having my medical and demographic information shared with other health care entities.

☐ Yes☐ No

Allergies

☐ Patient has no known allergies

☐ Patient has no known drug allergies

 Demerol

 IVP Dye

 Penicillins Propofol Codeine Sulfate

 Lortab

☐ Ambien

 Latex

☐ Versed

 Sulfa
(Sulfonamide
Antibiotics)

Other: _____ Other: _____

Immunizations

☐ None Flu Vaccine Hep B

☐ PPD/TB Skin Test

 Pneumonia Vaccine

When:_____ When:_____

When: _____ When: _____

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[illegible]

Diagnostic Studies/Tests

☐ None

☐ Abdominal
Ultrasound

When: _____

☐ Barium Swallow

When: _____

☐ Colonoscopy

When: _____

☐ CT Abdomen

When: _____

☐ HIDA Scan

When: _____

☐ Sigmoidoscopy

When: _____

☐ Test for Blood in
Stool

When: _____

☐ Upper
Endoscopy/EGD

When: _____

☐ Esophageal
Motility Study

When: _____

Other: _____

Previous Procedures

☐ None

☐ Appendectomy/Appendix

When: _____

☐ Cholecystectomy/Gallbladder

When: _____

☐ Colon Surgery

When: _____

☐ Defibrillator

When: _____

☐ Gastric Bypass

When: _____

☐ Heart Bypass

When: _____

☐ Heart Valve
Replacement

When: _____

☐ Hemorrhoid
Surgery

When: _____

☐ Hernia Repair

When: _____

☐ Hysterectomy

When: _____

☐ Pacemaker

When: _____

☐ Paracentesis

When: _____

☐ Prostate
Surgery

When: _____

Other: _____

Other: _____

Past or Present Medical Conditions

☐ None

☐ Anemia

☐ Anxiety/Depression

☐ Arthritis

☐ Atrial Fibrillation

☐ Barrett's
Esophagus

☐ Bleeding
Disorders

☐ Blood Clots
(DVT)

☐ Cancer

☐ Celiac Disease

☐ Cirrhosis

☐ Colon Polyps

☐ Congestive
Heart Failure

☐ Crohn's Disease

☐ Diabetes
(Insulin
Dependent)

☐ Diabetes (Non
Insulin
Dependent)

☐ Diverticulitis/Diverticulosis

☐ Gallstones

☐ GERD or reflux
disease

☐ GI Bleeding

☐ Heart Attack

☐ Hemorrhoids

☐ Hepatitis C

☐ High Blood
Pressure

☐ HIV

☐ Irritable Bowel
Syndrome

☐ Kidney Dialysis

☐ Liver Disease

☐ Pancreatitis

☐ Pulmonary
Embolism

☐ Seizure Disorder

☐ Stroke

☐ Ulcer Disease

☐ Ulcerative Colitis

Other: _____

Other: _____

Social History

Occupation: _____

Marital Status

☐ Single

☐ Married

☐ Divorced

☐ Separated

☐ Widowed

Alcohol

☐ None

Type

Quantity

Number

Frequency

Caffeine

☐ None

Intake: _____

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**Drug Use**☐

None

Type

Quantity

Number

Frequency

Exercise☐

None

Type

Quantity

Number

Frequency

Review Of Systems**Constitutional**☐ None

Y N

chronic fatigue

☐

fever

☐

weight loss

☐**Integumentary**☐ None

Y N

bruising

☐

rash

☐**Hematologic/Lymphatic**☐ None

Y N

anemia

☐

blood disorders

☐

easy bleeding

☐**Musculoskeletal**☐ None

Y N

weakness

☐

back pain

☐

joint pain

☐**ENMT**☐ None

Y N

deafness

☐

dizziness

☐

mouth or throat sores

☐

hoarseness

☐**Respiratory**☐ None

Y N

asthma

☐

wheezing

☐

cough

☐

shortness of breath

☐**Cardiovascular**☐ None

Y N

chest pain

☐

palpitations

☐**Gastrointestinal**☐ None

Y N

diarrhea

☐

constipation

☐

heartburn

☐

stomach cramps

☐

nausea

☐

vomiting

☐

blood in stool

☐

blood on the tissue paper

☐

bloating

☐

jaundice

☐

gas

☐

trouble swallowing

☐

abdominal pain

☐**Genitourinary**☐ None

Y N

increased urinary frequency

☐

change in urine color

☐

prostate problems

☐**Neurological**☐ None

Y N

stroke

☐

numbness

☐**Psychiatric**☐ None

Y N

bad nerves

☐

depression

☐

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon Polyps

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather
Health Status								
Cause of Death								
Diagnoses								
Gallstones	☐	☐	☐	☐	☐	☐	☐	☐
Pancreas problems	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐
Colon polyps	☐	☐	☐	☐	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐	☐	☐	☐
Stomach ulcers	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	First Cousin
Health Status					
Cause of Death					
Diagnoses					
Gallstones	☐	☐	☐	☐	☐
Pancreas problems	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐
Colon polyps	☐	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐
Stomach ulcers	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐