GASTROENTEROLOGY ASSOCIATES of Central Virginia

121 Nationwide Drive, Suite A
Lynchburg, VA 24502
Phone: 434-384-1862
Fax: 434-384-7704

Dear Patient:

Please complete this packet to the best of your knowledge, front and back of each page. Once you have completed the packet return to the above address and allow two weeks for the forms to be processed. Once this paper work is returned an appointment will be made. Thank You

Patients Full Name: ______________________________ **Maiden:** ______________

Preferred Name/Nickname: ______________________ **Gender:** M F Other: _____

Date of Birth: _________________ **Martial Status:** Married Widow Divorced Single

Social Security: ___________________ **Language:** English Spanish Other: __________

Race: __________________________ **Ethnicity:** ____________________________

Mailing Address: ____

City: ___________________________ **State/Zip Code:** ________________________

Home Phone: ___________________ **Cellular Phone:** _________________________

Employer: _________________________________ **Work Phone:** _______________

Email Address: ____

Family Physician: ____

Family Physician Phone Number: ____

Primary Insurance Company Name: ____________________________

Insurance Co. Address: ____

Policy Holder Name: ______________________________ **DOB:** _________________

Policy / ID Number: _________________________ **Group Number:** _______________

Secondary Insurance Company Name: ______________________

Policy Holder's Name: ____

Insurance Co. Address: ____

Policy / ID Number: _______________________ **Group Number:** _________________

Please make sure that this entire form is completed. Incomplete forms may cause delays.

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Today's Date:

Patient Name: (First,Middle,Last)		Family Physician:
Age:	**Height:**	**Weight:**
Date of Birth:	Gender: ☐ Female ☐ Male	

Open Access Colonoscopy is indicated for healthy patients, who need a colonoscopy for colon cancer or surveillance of colon polyps. If you have symptoms or do not meet these criteria you will be scheduled for an appointment with a nurse or nurse practitioner in our office.

We will need to send a bowel prep prescription to your pharmacy, please indicate the pharmacy of your choice.

Pharmacy:
Location:
Phone #:

Allergies to Medications:	NONE	1.
2.	3.	4.
5.	6.	7.
Are you allergic to LATEX? ☐ Yes ☐ No		

Please list **ALL MEDICATIONS** (include all herbals, vitamins, and over the counter medications you take):

Medication	Strength	How Often you Take	Reason for Taking

I would prefer my colonoscopy be scheduled with (please check one of the following):

☐ First Available Doctor			
☐ Dr. Catalano	☐ Dr. Richards	☐ Dr. Wisniewski	☐ Dr. Nunn
☐ Dr. Maffei	☐ Dr. Clark	☐ Dr. Hou	☐ Dr. Musana
Please contact me at the following number to discuss my appointment:			

Colon Health History: (please check any that apply)

☐ Colon cancer screening ***Average Risk-- age 50 to 80*** (NO family history of colon cancer or colon polyps).

☐ Colon cancer screening for ***African Americans age 45 to 80.***

☐ Colon cancer screening for ***HIGH Risk Individual***. This is indicated if any of the following family members have had **colon cancer**: Mother, Father, Brother, Sister or Child. You should be screened at age 40 or 10 years before your relative's age at the time he or she was diagnosed with colon cancer. For Example: Family member diagnosed at 44 with colon cancer... you should be screened at age 34.

☐ If you have ever had Colon Polyps.

☐ If you have a personal history of colon cancer.

☐ If you have ever had a Colonoscopy, please indicate the date:

____

Please check Yes or No to the following list:

Yes	No		Yes	No	
		Pacemaker			Cardiac Defibrillator
		Heart Stent Placement			Angina
		Heart Valve Replacement			Prosthetic Heart Valve
		Congestive Heart Failure			Lung Disease
		Sleep Apnea *Requires: C-PAP/BI-PAP Machine			Use of Oxygen Daily
		Kidney Disease			Diabetes REQUIRING INSULIN or 3 or more medications.
		High Blood Pressure			Hemophiliac
		Von Willebrand's Disease			Other Blood Disorder
		MRSA (Methicillin Resistance Staph Aureus)			VRE (Vancomycin Resistant Enterococcus)

Do you take any of the following medications:

☐ Coumadin	☐ Warfarin	☐ Plavix	☐ Pradaxa
☐ Effient	☐ Aggrenox	☐ Lovenox	☐ Other: ____________

Patient Signature: ______________________________ Date: ________________________

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer.
434-384-1862

Effective Date: April 14, 2003 **Revised: September 23, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment, or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: www.gastrocentralva.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share you PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights law.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for you health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment or services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically no to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. This should be directed to our privacy officer.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of your records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare options. We are not required to agree with these requests. If we agree to a restriction request we will honor the restrictions request unless the information is needed to provide emergency treatment.

There is one exception: We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment to your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Office Manager
121 Nationwide Drive
Lynchburg, VA 24502

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and became effective on April 13, 2003. Notice was revised on September 23, 2013.

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Notice of Privacy Practices
Acknowledgement

I have read a copy of the Gastroenterology Associates of Central VA Notice of Privacy Practices, revised September 23, 2013. I understand that Gastroenterology Associates of Central VA has the right to change its Notice of Privacy Practices from time to time and that I may contact Gastroenterology Associates of Central VA at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: **Patient #:**

Date of Birth:

Signature: ______________________________

Date:__________

Witness:______________________________

Date:__________

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AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I give permission for Gastroenterology Associates of Central Virginia, Inc. to discuss my Protected Health Information with the person(s) listed below. Protected Health Information includes but is not limited to diagnosis, current treatment, future treatment, appointments, medications, billing and insurance issues.

Name Relationship/Phone Number

____

____

____

____

____

****Anyone calling to discuss your Protected Health Information must be on this list and must be able to give us the Patient's Date of Birth as indicated on this form.****

Patient Full Name:

Patients Date of Birth:

Signature: ______________________________

Date: ______________________________

Web Page Download

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INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT

Gastroenterology Associates currently participates with Medicare, Piedmont Community Health Plan, Anthem (both PPO and PAR networks), Aetna, United Healthcare/Mamsi, Southern Health/Coventry, Medallion Medicaid and Virginia Premier Medicaid. It is the patient's responsibility to make sure the initial referral to be seen in our office has been arranged through the primary care physician if required by insurance.

***We will be glad to file any two insurances for you but you will be responsible for any fees not covered by your insurance plan. ***

IF YOU HAVE MEDICARE:

I request that payment of authorized Medicare benefits be made to Gastroenterology Associates of Central Virginia, Inc. for any services furnished by one of their Practitioners.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

OTHER INSURANCES:

I agree to be financially responsible for all fees. I authorize the release of any medical information necessary
to process any insurance claim(s) and request payment be made directly to Gastroenterology Associates of Central Virginia, Inc.

Collection Fee:

I understand that if my account with Gastroenterology Associates of Central Virginia, Inc. becomes delinquent
and is placed in collections, a 25% collection fee will be added to my balance owed.

No Show Fee:

I understand that should I need to cancel or reschedule my appointment, this should be done no later than the day before the appointment. Failure to do so may result in a $50.00 charge.

Patient

Signature:____________________ **Date:**________________

(A) Notifier(s): Gastroenterology Associates of Central VA	Patient Chart #:
(B) Patient Name:	(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) the procedure below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) procedure below.

Procedure: (D)	Reason Medicare May not Pay:	Estimated Cost: (F)
☐ Screening Colonoscopy ☐ Diagnostic Colonoscopy	☐ Colonoscopy with no or low risk is only covered once every 10 years. ☐ Colonoscopy with high risk is only covered once every 24 months. ☐ Medicare does not guarantee payment until claim is received.	Colonoscopy no more than $550.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) procedure listed above.

NOTE: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) **Options:** **Check only one box. We cannot choose a box for you.**
☐**OPTION 1**. I want the (D) colonoscopy listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐**OPTION 2.** I want the (D) colonoscopy listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐**OPTION 3.** I don't want the (D) colonoscopy listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I)	(J)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collections is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850

Form CMS-R-131 (03/11) **Form Approved OMB No. 0938-0566**