

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 received and processed. Once this paper work is returned an appointment will be made.**

**If you plan to return this paper work to the office, please sign in and have a seat. You will be called to the receptionist in the order you arrived. Thank You**

**Patients Full Name:** \_\_\_\_\_ **Maiden:** \_\_\_\_\_

**Preferred Name/Nickname:** \_\_\_\_\_ **Gender:** M F Other: \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Marital Status:** Married Widow Divorced Single

**Social Security:** \_\_\_\_\_ **Language:** English Spanish Other: \_\_\_\_\_

**Race:** \_\_\_\_\_ **Ethnicity:** Hispanic or Latino Not Hispanic or Latino

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State/Zip Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cellular Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Family Physician:** \_\_\_\_\_

**Family Physician Phone Number:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Please contact me at the following number to discuss my appointment:** \_\_\_\_\_

**\*\*\* Please complete insurance information on back \*\*\***

## Insurance Information:

Please take a moment to look at your card and complete the following information:

**Primary Insurance Company Name:** \_\_\_\_\_

**Insurance Co. Address:** \_\_\_\_\_

**Does your card say? (Please circle one)**    PPO   HMO   POS   PFFS   NONE OF THESE

**Policy Holder Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Is there a doctor or physician group listed on your card? If yes, who?** \_\_\_\_\_

**Policy / ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Secondary Insurance Company Name:** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Does your card say? (Please circle one)**    PPO   HMO   POS   PFFS   NONE OF THESE

**Insurance Co. Address:** \_\_\_\_\_

**Is there a doctor or physician group listed on your card? If yes, who?** \_\_\_\_\_

**Policy / ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Please provide us with a copy of your insurance card(s) front and back.**

**\*\* YOU MAY NEED A REFERRAL TO BE SEEN BY OUR PROVIDER. PLEASE CHECK WITH YOUR INSURANCE CARRIER.**

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

Today's Date:

Patient Name: (First,MI,Last)
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Allergies to Medications:	<input type="checkbox"/> NONE	1.
2.	3.	4.
5.	6.	7.
Are you allergic to LATEX? <input type="checkbox"/> Yes <input type="checkbox"/> 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

(Please attach additional pages if necessary)

Today's Date:

Patient Name:  
(First,MI,Last)

Height: Weight:

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 provider 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 #:

Are you able to walk unassisted?  YES  NO  
Do you require:  Wheelchair  Walker  Cane  Bathroom Assistance

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

<input type="checkbox"/> First Available Doctor			
<input type="checkbox"/> Dr. Richards	<input type="checkbox"/> Dr. Wisniewski	<input type="checkbox"/> Dr. Maffei	<input type="checkbox"/> Dr. Clark
<input type="checkbox"/> Dr. Hou	<input type="checkbox"/> Dr. Musana	<input type="checkbox"/> Dr. Kenny	

**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 **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. Additionally if you have any immediate family members with history of precancerous polyps.

If you have ever had Colon Polyps.

If you have personal history of colon cancer.

If you have ever had a Colonoscopy, please indicate the date and location (please obtain a copy if not at Gastroenterology Associates): \_\_\_\_\_

Please complete back page.

Patient Name:  
(First, MI, Last)

Please check if you have any of the following:

Pacemaker

Heart Stent Placement. If yes date placed?

Heart Valve Placement

Congestive Heart Failure

Sleep Apnea - Do you use a CPAP/BI-PAP machine?

Kidney Disease

High Blood Pressure

MRSA (Methicillin Resistance Staph Aureus)

Chronic Constipation

Cardiac Defibrillator

Angina

Prosthetic Heart Valve

Lung Disease (Such as COPD, Emphysema)

Use of home oxygen

Diabetes Requiring Insulin or 3 or more medications

Cirrhosis of Liver

VRE (Vancomycin Resistant Enterococcus)

Do you have any bleeding disorders such as, Factor V Leiden, Hemophiliac, Von Willebrand's Disease?

Are you currently on prescription blood thinning medications such as; Coumadin, Warfarin, Plavix/Clopidogrel, Pradaxa, Eliquis, Effient, Aggrenox, or Xarelto? \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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GASTROENTEROLOGY  
ASSOCIATES  
*of Central Virginia*

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

### **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.**

**Effective date: April 14, 2003**

**Revised date: February 26, 2016**

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 disclosure (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 the 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](http://www.gastrocentralva.com)

### **Uses and Disclosure 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 or 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 your 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 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 requirement for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining the 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 your 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 your notice of treatment options or other health related services that may improve your overall health.
- Appointment reminders: By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging systems to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

**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 of services. If you are not present or able to agree/object, the healthcare provider using professional judgement 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 not 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 authorizations simply explain 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 request 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 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 purpose 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 of 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 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 purpose 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 the 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 Ste A., 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 February 26, 2016.



I have received a copy of the Gastroenterology Associates of Central VA Notice of Privacy Practices, revised February 26, 2016. 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.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# GASTROENTEROLOGY ASSOCIATES *of Central Virginia*

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

## INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT

Gastroenterology Associates currently participates with Piedmont Community Health Plan, Anthem PPO, Anthem Healthkeepers HMO, Aetna, Cigna and United Healthcare. We also participate with many Medicare and Medicaid products, as well as some other commercial carriers. Please call the number on your insurance card to verify if we participate with your plan. 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:** \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I give permission for Gastroenterology Associates of Central Virginia, Inc. to release my protected information to the individual(s) listed below as described below:

Name:	Relationship: Phone #	<input type="checkbox"/>	<input type="checkbox"/> Discuss Treatment	<input type="checkbox"/> Billing	<input type="checkbox"/> All
Name:	Relationship: Phone #	<input type="checkbox"/>	<input type="checkbox"/> Discuss Treatment	<input type="checkbox"/> Billing	<input type="checkbox"/> All
Name:	Relationship: Phone #	<input type="checkbox"/>	<input type="checkbox"/> Discuss Treatment	<input type="checkbox"/> Billing	<input type="checkbox"/> All
Name:	Relationship: Phone #	<input type="checkbox"/>	<input type="checkbox"/> Discuss Treatment	<input type="checkbox"/> Billing	<input type="checkbox"/> All

Voice messages maybe be left at (phone number) regarding my:  
 Appointments     Lab Results     Procedure Results     Billing     All

**Patient Rights:**

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not conditioned on signing.

\*Description of Personal Representative's Authority (attach necessary documentation)

This authorization will remain in effect until I revoke it in writing.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(A) Notifier(s): Gastroenterology Associates of Central VA	
(B) Patient Name:	

## ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D). **Screening Colonoscopy** 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) **Screening Colonoscopy** below.

Procedure: (D)	Reason Medicare May not Pay:	Estimated Cost: (F)
<input type="checkbox"/> Screening Colonoscopy	<input type="checkbox"/> Colonoscopy with no or low risk is only covered once every 10 years. <input type="checkbox"/> Colonoscopy with high risk is only covered once every 24 months. <input type="checkbox"/> Medicare does not guarantee payment until claim is received.	Colonoscopy ranging in price from approximately \$550-\$3,300.

**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) Screening Colonoscopy 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.

<b>(G) Options:</b>	<b>Check only one box. We cannot choose a box for you.</b>
<input type="checkbox"/> <b>OPTION 1.</b> I want the (D) <b>Screening Colonoscopy</b> 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.	
<input type="checkbox"/> <b>OPTION 2.</b> I want the (D) <b>Screening Colonoscopy</b> 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.	
<input type="checkbox"/> <b>OPTION 3.</b> I don't want the (D) <b>Screening Colonoscopy</b> listed above. I understand with this choice I am <b>not</b> 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)	
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CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).  
 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 (Exp. 06/30/2023) Patient #: 122120 Form Approved OMB No. 0938-0566