

Mid-Atlantic G.I. Consultants, PA.

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Diplomates of American Board
of Internal Medicine

Diplomates of American Board
of Gastroenterology

Dear Patient,

Mid-Atlantic G.I. Consultants would like to thank you for choosing our practice. In order to better meet the needs of our patients we created a system that allows patients to avoid unnecessary office consultations prior to procedures.

Listed below are simple steps to schedule your procedure.

Carefully read and complete the information enclosed.

Please MAIL or FAX (302-225-2388) the following information: You may choose to scan (all the documents with signature & insurance card) and email to scheduling@midatlanticgi.com.

- 1. Please make a photocopy, front and back, of current insurance card(s).**
- 2. Completed Medical History and Medical Registration forms.**
- 3. Reading and Signing of Financial Policy.**
- 4. Medicare authorization (for patients applicable).**

Our Scheduling department will contact and schedule you upon receipt of this information.

If there are any questions please call.

Tel: (302) 225-2380

Fax: (302) 225-2388

Mid-Atlantic GI Consultants, PA
537 Stanton Christiana Road. Suite 203,
Newark, DE 19713

Mid-Atlantic G.I. Consultants, P.A.

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PATIENT REGISTRATION FORM (Downloaded)

Please complete/ Update Form

Date _____ Are you? New Patient Existing Patient

If you are an existing patient, name of your GI doctor: _____

Allergies _____ Allergic/Sensitive to Latex? Yes No

Name _____
Last First M.I.

Birth date _____ Age _____ SS# _____

Male Female Marital Status: _____

Address _____

City _____ State _____ Zip/P.C. _____

Home# _____ Work _____ Mobile/Cell # _____

Email Address: (if present) _____

Can we call you at work to schedule the procedure (if we can't reach you at home or Cell)

Yes No _____

Spouse's Name _____ D.O.B. _____

In the event of an emergency, whom should we contact? Name _____

Relationship _____ Emergency Contact No: _____

May we share your medical information with family member(s) or friend(s)? Yes No

If 'Yes', with whom? Name(s) _____ Relationship(s) _____

Telephone: _____

Reason for referral: Office Visit Colonoscopy Upper Endoscopy Other _____

PCP doctor: _____ Phone# _____

Referring doc (if not PCP): _____ Phone# _____

Pharmacy Name _____ Phone# _____

Your Employer: _____ Your Occupation _____

Primary Insurance

Insurance Company _____

Member ID# _____

Group# _____

Co-pay/Deductible Amount _____

Ins. Co. Address _____

Secondary Insurance

Insurance Company _____

Member ID# _____

Group# _____

Co-pay/Deductible Amount _____

Ins. Co. Address _____

Please fill below if you are not the subscriber:

Subscriber Name _____

Relationship to Patient _____

Subscriber Birth Date _____

Subscriber SSN _____

Subscriber Employer _____

Subscriber Name _____

Relationship to Patient _____

Subscriber Birth Date _____

Subscriber SSN _____

Subscriber Employer _____

**CONSENT FOR RELEASE OF INFORMATION,
AUTHORIZATION, AND ASSIGNMENT
FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

I, _____ CERTIFY THAT THE INFORMATION I HAVE COMPLETED ON THIS REGISTRATION FORM IS CORRECT AND CURRENT TO THE BEST OF MY KNOWLEDGE.

I, _____, hereby authorize *Mid-Atlantic G.I. Consultants, P.A.* to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out treatment, payment, and health care operations. Specifically, I authorize the release of my medical information to my insurance company or companies. I understand that while this consent is voluntary, if I refuse to sign this consent, the physicians of *Mid-Atlantic G.I. Consultants, P.A.* can refuse to treat me.

I have been informed that *Mid-Atlantic G.I. Consultants, P.A.* has prepared a "Notice of Privacy Policies" pamphlet which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I will be offered a copy of this pamphlet and will have the right to review it prior to signing this consent.

I understand that I may revoke this consent at any time by notifying *Mid-Atlantic G.I. Consultants, P.A.* IN WRITING, but if I revoke my consent, such revocation will not affect any actions that *Mid-Atlantic G.I. Consultants, P.A.* took before receiving my revocation.

I understand that *Mid-Atlantic G.I. Consultants, P.A.* has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that *Mid-Atlantic G.I. Consultants, P.A.* restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations, I understand that *Mid-Atlantic G.I. Consultants, P.A.* does not have to agree to such restrictions, but that once such restrictions are agreed to, *Mid-Atlantic G.I. Consultants, P.A.* must adhere to such restrictions.

I REQUEST THAT PAYMENTS ISSUED FROM MY INSURANCE COMPANY, OR COMPANIES, BE MADE TO: *Mid-Atlantic G.I. Consultants, P.A.*

Signature of patient or patient's representative

Date

PRINT name of patient or patient's representative

Relationship to patient

Mid-Atlantic G.I. Consultants, P.A

537 Stanton Christiana Road. Suite 203, Newark, DE 19713 • (302) 225-2380 • Fax (302) 225-2388

MEDICAL HISTORY Date: _____

Please complete this history form. This will allow us to best serve your health needs. The information contained herein is strictly confidential and will not be released without your permission.

NAME: _____ Birth Day: _____

Last First MI

Height: _____ Weight: _____ Reason for Referral: EGD ___ Colonoscopy ___ Office visit ___

Family Doctor's Name and Phone Number: _____

Cardiologist's Name and Phone Number: _____

FAMILY HISTORY

FAMILY	Sex	Age	Health Problems.
Father	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>		
Mother	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>		
Brothers/Sisters			
Sons/ Daughters			

Do you have any immediate family with the following: (Indicate relationship)

Cancer of the colon, rectum: _____ Liver disease (indicate type): _____

Primary Cancer of other organs: _____ Ulcerative colitis or Cohn's disease: _____

MEDICATION HISTORY:

Are you currently taking Coumadin (Blood thinner)? Yes ___ No ___ Dose _____

Please indicate if you are taking non-steroidal anti-inflammatory (like Motrin or aspirin)

List all medications including OTC	Daily Dose	How Often?

ALLERGIES: List the meds or injections that have given bad reactions. Please include your reaction (hives, rash, itching, headache, nausea, passed out, shortness of breath)

Name	Type of reaction	Year

Latex Allergy/ Sensitivity? Yes ___ No ___ **Explain:** _____

PAST HISTORY- Heart Problems

Have you had any heart testing scheduled/performed in the last 6 months? Yes No

Coronary Artery Disease	Yes	No	Arrhythmias	Yes	No
Congestive Heart Failure	Yes	No	Pacemaker	Yes	No
Emphysema/COPD	Yes	No	Home Oxygen	Yes	No
Sleep Apnea (machine use)	Yes	No	Asthma	Yes	No
Difficulty with anesthesia or intubation				Yes	No

If Yes, explain _____

KIDNEY PROBLEMS

Kidney insufficiency	Yes	No	Dialysis	Yes	No
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OTHER MEDICAL PROBLEMS

Diabetes	Yes	No	On a transplant list	Yes	No
Hypertension	Yes	No	Cancer	Yes	No

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE: _____

Past Surgical History/Operations/

Last Flexible Sigmoidoscopy Performed: When _____ Findings _____

Last Colonoscopy performed: Year _____ Finding _____

Last Upper Endoscopy Performed: Year _____ Finding _____

SOCIAL HABITS (Please circle yes or No)

Yes No Do you smoke currently or past? Cigarettes, pipe, cigar? Packs/day ___ yrs ___

Yes No Have you stopped smoking? When? _____

Yes No Do you drink alcohol? Type: Wine/ Beer /Liquor/ others: _____

Amount of alcohol consumed (oz/ btl) per day/ week: _____

Yes No Do you currently use/ Have you ever used? Marijuana heroin cocaine LSD

PCP Current use _____ in the past (mention how long used) _____

GASTROINTESTINAL

Yes	No	Rectal bleeding	Yes	No	Loss of appetite
Yes	No	Troubled by heartburn >6 months	Yes	No	Difficult swallowing
Yes	No	Nausea	Yes	No	Vomiting
Yes	No	Upper abdominal pain (stomach)	Yes	No	Lower abdominal pain
Yes	No	Diarrhea	Yes	No	Constipation
Yes	No	Vomited blood	Yes	No	Black stools
Yes	No	Bloating after eating	Yes	No	Pets at home
Yes	No	Excessive gas	Yes	No	Trouble with drinking milk
Yes	No	Chills/fever	Yes	No	Weight loss
Yes	No	Night sweats	Yes	No	Itching
Yes	No	Flushing	Yes	No	Usually feel depressed
Yes	No	Weakness/ tiredness	Yes	No	Ever sought psychiatric help

PRESENT PROBLEMS:

Use the space below to describe your symptoms. If you have questions, write them down so they will not be forgotten. Thank you.

Whom can we thank for referring you to our practice? _____

WE TAKE FOLLOWING INSURANCE
(FOR YOUR INFORMATION, DON'T SEND IT TO US)

AMERIHEALTH NJ HMO-POS
AMERIHEALTH ADMINISTRATORS
AMERIHEALTH
AMERICAN PROGRESSIVE (TODAYS OPTIONS)
AETNA/USHC HMO, PPO INDEMNITY
ADVANTRA (THROUGH COVENTRY)
BC/BS OF DE IPA, P0S, PPO, MANAGED CARE, PRE-CERT
BC/BS OF MD PPO, PPN, BLUE CHOICE, P0S
BC/BS NATIONAL ACCOUNTS (CHRYSLER, GM, ETC
CAREFIRST BC/BS PPO
OUT OF STATE BC/BS WITH SUITCASE LOGO (PPO)
FEDERAL BC/BS
CHAMPUS (NOT HMO)
CIGNA HMO, PPO INDEMNITY
CORESOURCE (ALLIANCE OR PHCS NETWORKS)
COVENTRY
DEFINITY HEALTH PLAN
DELAWARE PHYSICIANS CARE
DEVON HEALTH CARE
DIAMOND STATE PARTNERS
FIDELITY BENEFIT ADMINISTRATORS
FIRST HEALTH PLAN
GREAT WEST
HEALTH CARE PREFERRED
KEYSTONE
MAMSI
MDIPA/OPTIMUM CHOICE
MEDICAID (MARYLAND & DELAWARE)
MEDICARE
ONE NET PPO
PRIMARY SELECT
PRO-NET (ONLY IF ALLIANCE NETWORK)
PRIVATE HEALTHCARE SYSTEMS (PHCS)
TRICARE (BUT NOT HMO)
UNITED HEALTH CARE PPO
UNISON

WE DONOT TAKE

AMERICHoice/AMERIGROUP/AMERICAID
BEECH STREET
CAREFIRST BC/BS BLUECHOICE PLAN
CIGNA HMO OF NJ
DIAMOND PLAN
FAMILYFIRST MARYLAND MEDICAID PLAN
EMPLOYERS HEALTH PLAN
HORIZON MERCY
ONE HEALTH PLAN
OXFORD HEALTH PLAN
INTERGROUP
MARYLAND PHYSICIANS CARE
MHIP (MARYLAND HEALTH INS PLAN)
PRIORITY PARTNERS
TRICARE HMO
PREFERRED HEALTH NETWORK (PHN)
UNITED HEALTH CARE FAMILY FIRST (MEDICAID MGD CARE)
UNITED HEALTH CARE OF MID-ATLANTIC HMO

***IF YOU DO NOT SEE YOUR INSURANCE LISTED HERE, PLEASE
CALL OUR OFFICE AT 302-225-2380**

MID-ATLANTIC G. I. CONSULTANTS, P.A.
FINANCIAL POLICY

This Practice is dedicated to providing our patients with the best possible care and service while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy.

INSURANCES:

We participate with several insurance companies. It is up to you as a patient to determine whether or not we are in network with your insurance company.

If we do participate with your insurance company, all services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. **All copays and deductibles are the patient's responsibility and will be billed to you by our office.**

HMO insurances may require referrals for services. It is the patient's responsibility to obtain the referral prior to the time of service. **If a referral is not presented at the time of service, the patient will be responsible for payment in full for that service at the time of service.** All patients are responsible for ALL co-payments prior to services being rendered.

If we do not participate with your insurance company, this means that we will not bill your insurance carrier and we will not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay. However, the doctor's fees may be more than what the insurance company shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient. **Payment for office visits is due at the time of service.** We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company, and your doctor's bill for the services provided to you is an agreement between you and your doctor.

PAYMENT FOR SERVICES PERFORMED:

Our office accepts Visa/MasterCard/American Express for your convenience, as well as cash, check, or money order. All payments are expected at the time of service and any outstanding balances are due within 30 days, unless prior arrangements have been made with the Billing Department. All **balances that reach 90 days past due will be sent to a collection agency.** Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

MISSED APPOINTMENTS POLICY:

Effective April 15, 2010- if you are unable to keep an appointment, you must notify this office within 24 hrs for an office visit, and 72 hours for a procedure, or you will be charged 25\$ for missed office visit and 100\$ for a missed procedure appointment's fee: Patients will be billed directly for this charge. Payment is expected within thirty (30) days from receipt of the bill.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY MID-ATLANTIC G.I. CONSULTANTS, P.A., AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Signature of Patient and/or Guarantor

Date

PATIENT'S MEDICARE AUTHORIZATION
(MEDICARE PATIENTS ONLY)

PATIENT'S NAME: _____

MEDICARE #: _____

I request payment of authorized Medicare benefits be make on my behalf to *Mid-Atlantic G. I. Consultants, P.A.* for any services rendered to me by them. 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 to related services.

I understand that my signature requests that payment(s) be made to *Mid-Atlantic G.I. Consultants,P.A.* and authorizes release of my medical information necessary to pay the claim(s). If other health insurance is indicated on the HCFA 1500 Claim Form or on an electronically submitted claim, my signature authorizes release of information to the insurer or agency shown.

In Medicare-assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. I understand that I am responsible for the deductible, co-insurance and non-covered services. The co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Signature of patient or patient's representative

Date

**NOTICE OF PRIVACY POLICIES FOR
MID-ATLANTIC G. I. CONSULTANTS, P.A.
(THIS PRIVACY POLICY IS FOR YOUR INFORMATION ONLY, NO NEED
TO FAX/SEND BACK TO US)**

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE
REVIEW IT CAREFULLY.

Introduction

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). We are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit our practice, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of our practice, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of information practices upon request,
- Inspect and copy your health record,
- Amend your health record,
- Obtain a report of disclosures of your health information,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:

- Maintain the privacy of your health information,
- Provide you with this Notice which describes our legal duties and privacy practices with respect to information we collect about you,
- Abide by the terms of this Notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to revise this Notice and to make the new provisions effective for all protected health information we maintain. Should this Notice be revised, we will post a copy of the Notice and will make it available to you when you arrive for services.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization.

For More information or to Report a Problem

If you have questions and would like additional information, you may contact our Privacy Officer by contacting our office.

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Office for Civil Rights. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW.
Room 509F, HHH Building
Washington, D.C. 20201

How we may Use and Disclose Medical Information About You?

We may disclose information about you in regards to your 1. Treatment, 2. Payment, and 3. HealthCare Operations.

1. TREATMENT.

We may use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians, or other medical personnel who are involved in taking care of you.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

2. PAYMENT.

We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company, or a third party.

For example: A bill may be sent to you or your insurance company. The bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

3 HEALTHCARE OPERATIONS.

We may use and disclose medical information about you in our regular course of business.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: Some of the services we provide are through contacts with business associates. Examples include services in the laboratory, radiology, emergency room, hospital, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Answering Machine: We may disclose health information to you at the phone number you have provided to us. Examples: appointment reminders, answering your questions, medication changes, lab results, and as a follow up to procedures, etc.

Emergency: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would only disclose that information to help prevent the threat.

Treatment Alternatives: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

To Report Suspected Abuse, Neglect or Domestic Violence:

We may notify government authorities if we believe that you are a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Research: With your authorization, we may disclose 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 health information.

Food & Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Health Oversight and Legal: We may disclose health information for law enforcement purposes as required by law or in response to a court or administrative order. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

REMINDER!!

- Please remember to include a copy of your current HEALTH INSURANCE CARD(S).
- Please-obtain and bring all required REFERRALS prior to your office visit or procedure.
- REFERRALS may be mailed, your PCP can fax referral, or you can personally bring it to our office
- COPAYS are due at time of each visit