CONNECTICUT GASTROENTEROLOGY ASSOCIATES,P.C.

www.gastroct.com

Patient Name (First, Middle, Last)	SEX □ Female □ Male	Maritul Status □ S □ M □ D □ W
Social Security#	Date of Birth	
Email Address		

Answers to Questions Below ARE Required by the Federal Government American Recovery & Reinvestment Act of 2009

Race	Ethnicity	Language
☐ Caucasian	☐ Hispanic/Latino	☐ English
☐ Black	☐ Not Hispanic/Latino	☐ Spanish
☐ Asian	☐ Caucasian	☐ French
☐ American Indian/Native Alaskan	☐ Other	☐ Polish
☐ Native Hawaiian/Pacific Islander	☐ Unknown	☐ Vietnamese
☐ Other Race		☐ Sign
☐ Unknown		☐ Other

Employment Status

☐ Employed ☐Unemployed ☐ Retired ☐ Part-Time Student

☐ Self-Employed ☐ Disabled ☐ Full-Time Student

Mailing Address		City	State
Home #	Mobile #	Work # & Extension	
Employer	Employer Address	City	State

Referring Physician Name and Address	Primary Physician Name and Address
Pharmacy Name and Address	

Primary Insurance Plan Name		Group #	Insurance ID#
Effective Date	Visit Copay $ Amount	Subscriber: □ Patient □ Parent □ Spouse □ Other	
Subscriber Name		DOB:	
Social Security #		Employer	
Secondary/Supplemental Insurance Plan Name		Group #	Insurance ID#
Effective Date	Visit Copay $ Amount	Subscriber: □ Patient □ Parent □ Spouse □ Other	
Subscriber Name		DOB:	
Social Security #		Employer	

Who should we contact in case of EMERGENCY?

Name	Phone #	Relationship to Patient:

I hereby authorize direct payment of medical/surgical benefits to Connecticut Gastroenterology Associates, P.C. for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I hereby authorize the release of any and all medical or other information for the purpose of processing my insurance claims.
A photocopy of my signature is as valid as the original.

Signature of Patient / Guarantor ______________________________________ **Date**______________________

Connecticut Gastroenterology Associates, PC.

Patient Information

Name: ____Date of Birth ___________Date___________

Please complete the following:

List allergies to medication: ____

List any prescription medication you take: ____

____

List any herbal medicine/over the counter medicines/vitamins: _______________________________

____

List all surgeries and dates: ____

____

List medical problems for which you are under care of a healthcare provider: ____________________

____

Do you smoke/former smoker? Yes __No__ How much per day? _____ How many years? _____
....drink alcohol/former drinker? Yes __No __ quantity per week ___________
….drink caffeinated beverages? Yes __ No __ quantity per day ____________
….use IV drugs or nasal cocaine? Yes __ No __ when? ____________________

Please indicate if you are experiencing any of the following at the present time:

Lack of energy	Changes in vision	Chest pain
Trouble sleeping	Post nasal drip	Palpitations
Weight loss	Sore throat	Swollen legs
Weight gain	Voice change	Shortness of breath
Fevers	Excessive thirst	wheezing
Constipation	Hormonal problems	Coughing up blood
Diarrhea	Frequent urination	Chronic cough
Nausea	Pain with urination	Painful menses
Vomiting	Blood in urine	Pregnant
Rectal bleeding	Joint swelling	New skin rash
Abdominal pain	Joint redness	Depression
Heartburn	Joint pain	Anxiety
Difficulty swallowing	Back pain	
Regurgitation	Muscle aches	
Sour taste in mouth		

_____MD/PA

CONNECTICUT GASTROENTEROLOGY ASSOCIATES, P.C.

WAIVER
DISCLOSURE/AGREEMENT

PATIENT NAME: ____

REASON FOR TODAY'S VISIT:

Routine Preventive Exam…I have no medical complaint or significant problem/ Abnormality that I am aware of

Yes, my insurance plan covers Preventive Medical Services

No, my insurance plan does not cover Preventive Medical Services

I do not know if my insurance plan covers Preventive Medical Services

- -

I do have a problem/ complaint that I wish to have evaluated/ treated by the doctor

My chief complaint is: ____

I agree to pay for any and all medical services I receive from the doctors / providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, plan does not pay for preventive medicine visits or my failure to secure a referral from my primary care physician) I will pay for same upon written/ verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit (s) with a diagnosis that was encountered and documented in my medical record. Thus, this office cannot comply with any request to improperly alter the medical record or claim for the purpose of securing payment from any insurance carrier which may be considered a fraudulent act (s).

In the event I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process.

Signature: ____

Patient (or responsible party if minor)

Print Name: ____

Witness: ____

Date: __________________________________

Connecticut Gastroenterology Associates, PC.

Confidential Channel Communication Request

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided

I give Connecticut Gastroenterology Associates, PC. Permission to contact me and/or the individual(s) I designate below regarding my personal medical information.

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Phone __ Tel # ______________________________

Do __ Do not__ leave messages on my answering machine

Mail __ address: __________________________________

Other ____

Please feel free to **share my personal medical information** with the individuals I've designated below:

1. Name: ____

   Relationship to patient: _______________________________Contact phone# _____________

2. Name: ____

   Relationship to patient: ________________________________Contact phone# ____________

Patient Name (Please print): __________________________________**Date of Birth** ____________

Patient Signature: ____**Date**: ____________________

If not signed by the patient, please indicate your relationship to the patient: ____________________

NOTICE OF PRIVACY PRACTICES CT.

GASTROENTEROLOGY ASSOCIATES Office Manager-Privacy Officer-Tel. 860-522-1171x305

1000 Asylum Ave Asylum Avenue Suite 3212 Hartford, CT 06105

18 Haynes Street Manchester, CT 06040 Suite A

Effective Date: 8/1/2013 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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

If you have any questions about this Notice, please contact our Privacy Officer listed above.

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Acknowledgement of Receipt of Notice

CT. GASTROENTEROLOGY ASSOCIATES, PC

Privacy Officer

Tel. 860-522-1171ext. 305

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Name of Patient ____

□ I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

□"I acknowledge and agree that the Group will enter my protected health information ("PHI") in a database maintained by the Saint Francis Hospital and Medical Center (the "Hospital"). The PHI maintained in the database will be used by this Group for treatment, payment and health care operations purposes. The Group may also disclose your PHI maintained in the database to another provider (i) for treatment purposes, (ii) for payment purposes and (iii) for health care operations if you have or had a relationship with the other provider and only for the following reasons: (a) evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; or (b) reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; or (c) health care fraud and abuse detection or compliance. The Group may also disclose your PHI maintained in the database to the Saint Francis Health Care Partners ("SFHCP") for use by the SFHCP as a Business Associate of the Group for health care operational purposes, including without limitation, quality and utilization review health care services."

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ______________________________.

Signed: _______________________________ Date: ___________________________

Print Name: ___________________________ Telephone: ______________________

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: ____

***For Office Use Only*:**

- ❑ Signed form received by: ____________________________
- ❑ Acknowledgment refused:

Efforts to obtain: ____

Reasons for refusal: ____

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CT. GASTROENTEROLOGY ASSOCIATES P.C.

1000 Asylum Ave, Suite 3212 Hartford, CT 06105 860-522-1171

18 Haynes Street Suite A Manchester, CT. 06040 Fax. 860-493-6524 Fax. 860-533-0019

Patient Authorization for Use or Disclosure of Protected Health Information

Medical Records Release/Request Form

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose for the disclosure.

I authorized medical practice____
(Name of practice) To release health information of patient named below.

Patient Name: ____Date of Birth ________________
Soc.Sec#____________________

(Print) (Other names, Maiden
name):____ Dates of
Service & description of health information to be disclosed:
1.___________________________2.__________________________3.____________________________4.
___________________________ OR □ ENTIRE MEDICAL RECORD Reason for
Release:____
(Reason for release must be noted on this form) Send medical records to:

Name: ____ Address:
____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusion (please initial): Drug / Alcohol _____, Mental Health / Psychiatric _____, Sexually Transmitted Disease _____, HIV/AIDS _____, Other ______, description of other exclusion

This authorization is effective from: ________________ thru ________________ (dates must be specified) Signature:
____ Print Name _______________________________ Date _____________ (Please check appropriate box) I am the: □ Patient □Guardian □Conservator □Patient's Representative (If this form was completed by someone other than the patient, please print name and address below).

Name: __________________________________ Address: ______________________________________ I understand that I have the right to receive a copy of this authorization.

Refusal to Sign Authorization_____________________________________ I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form. I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by HIPAA. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information. As Referenced in section 20c (b), CT General Statutes allow a charge of $.65 per page to copy medical records, plus shipping and handling or any conveyance fees the office is required to pay. Fees are payable in advance, by cash or credit card.

TRADITIONAL MEDICARE (Red, white and Blue) IMPORTANT INFORMATION!!!

14 BUSINESS DAYS advanced notice is **required** for cancellation/rescheduling of your procedure(s) or a fee of $150.00 will be billed to the patient.

UNVACCINATED Patients are **required** to have a COVID-19(Non rapid) test done 3 days before the date of procedure. Typically, you will receive a call from the nursing staff within one to three days prior to your procedure to pre-register you and confirm Vaccination status. You will be asked to present a copy of your Vaccination Record Card.

PATIENT IS RESPONSIBLE TO CHECK FULL COVERAGE WITH YOUR INSURANCE CARRIER BEFORE THE DATE OF YOUR SCHEDULED OUTPATIENT PROCEDURE. THIS INCLUDES, BUT NOT LIMITED TO OBTAINING AN INSURANCE REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN (PCP) IF ONE IS REQUIRED AND CHECKING WITH YOUR INSURANCE CARRIER BENEFIT DEPARTMENT TO DETERMINE IF THERE WILL BE ANY OUT-OF-POCKET EXPENSES. EXAMPLES: COPAYS, COINSURANCE/OR DEDUCTIBLES...

(Procedure codes are subject to change based on the Provider findings) **Please check benefit coverage for the following range of Screening codes:**

Colorectal cancer screening, for not High-risk patients CPT code G0121 cost$1300

Colorectal cancer screening Colonoscopy for High-Risk patient CPT code G0105 $1300

Dx Codes: ___________ ___________ ___________

Please note: if you have an **Out of State Insurance** plan the anesthesia used is Propofol (00811,00812(colon), (Endoscopy)00731 or 00732) may not be covered by your insurance. Please verify your benefits with the listed CPT codes prior to your scheduled date to assure the anesthesia is covered.

Please keep in mind the different components of your Billing for the procedure;

1. Professional component (Provider performing procedure)
2. Facility component (please verify cost with the facility selected)

3. Anesthesia Cost (please verify cost with Anesthesia Department from facility)
4. Pathology Cost (only if applicable/when a polyp or a growth is detected which results in a biopsy or removal of the growth)

CONNECTICUT GASTROENTEROLOGY ASSOCIATES

Payment Policy

Thank you for choosing us as your Gastroenterology care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

<u>If deductible is not met you will be required to pay $50.00 towards office visits and $250.00 towards any procedures.</u>

3. Non-covered services. 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. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours for an **office visit ($25.00) and 5 days prior to procedure ($100.00)**. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________________ _______________
Patient Name (Please Print) **DOB**

______________________________________ _______________
Signature of patient or responsible party **Date**