

**Gastroenterology Specialists of Oregon, P.C.**

**PATIENT INFORMATION: (Please Print)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_  Home  Work  Cell

Phone: \_\_\_\_\_  Home  Work  Cell

Patient ID #: \_\_\_\_\_

Sex:  Male  Female

Date of Birth: \_\_\_\_\_

Social Security #: XXX-XX-\_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widow

Referring Provider: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

**EMPLOYMENT:**

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

GSO will use reasonable means to protect the privacy of your health information sent by e-mail and text. However, GSO cannot guarantee that e-mail/text communications will be confidential. Additionally, GSO will not be liable in the event that you or anyone else inappropriately uses your e-mail or text messages. GSO will not be liable for improper disclosure of your health information that is not caused by GSO's intentional misconduct.

E-mail Address: \_\_\_\_\_

Is it OK to E-mail you? (circle one):    Yes    No

Is it OK to Text you? (circle one):    Yes    No

Text Message Phone #: \_\_\_\_\_

**PRIMARY INSURANCE COMPANY**

Ins Company: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_

**INSURED PERSON INFORMATION**

Name: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

Insured Person's Date of Birth: \_\_\_\_\_

Insured Party's Social Security #: XXX-XX-\_\_\_\_\_

**SECONDARY INSURANCE COMPANY**

Ins Company: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_

**INSURED PERSON INFORMATION**

Name: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

Insured Person's Date of Birth: \_\_\_\_\_

Insured Party's Social Security #: XXX-XX-\_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)**

I attest that the information I have given here is true and correct to the best of my knowledge. I hereby assign benefits to Gastroenterology Specialists of Oregon, PC and authorize them to furnish information regarding my treatment to my insurance company. I understand that my contract with my insurance company requires me to be compliant to the rules of my policy regarding referrals to medical specialists.

**I understand that I am responsible for all known visit co-pays at the time of service.**

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

\_\_\_\_\_  
Date



# GASTROENTEROLOGY

SPECIALISTS OF OREGON, PC.

DATE: \_\_\_\_\_

## ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

Unexplained Weight Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Difficulty Swallowing	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Poor Appetite	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Regurgitation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heartburn	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fatigue	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes to heartburn: Occurs at least 2-3x/week?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Blurred Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	History frequent heartburn for at least 3-5 yrs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hearing Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Nausea	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mouth Sores	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Vomiting	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chest Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bloating	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If yes to chest pain: Has this been evaluated?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Belching	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is it due to heart problems?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Constipation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Occurs with exercise?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diarrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Occurs at rest?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Abdominal Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Shortness of Breath	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Change in Bowel Habits	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Spitting up Blood	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Rectal Bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Swelling of Ankles	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Black, Tarry Stools	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Itching	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bleeding Tendency	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Memory Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bruising Tendency	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you Pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anxiety	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Do you use Tobacco?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
			Do you drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

## HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Congestive Heart Failure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Atrial Fibrillation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Emphysema	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cardiac Pacemaker	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bleeding Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cardiac Defibrillator	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sleep Apnea	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Artificial Heart Valve	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizure Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes



**Gastroenterology Specialists of Oregon, PC  
The Gastroenterology Endoscopy Center, Inc**

**Surgical History – List date and circle**

_____ Gallbladder	_____ Ulcer
_____ Colon Resection	_____ Hernia Repair
_____ Heart Bypass	_____ Heart Valve
_____ Appendectomy	_____ Hysterectomy
_____ Tonsillectomy	
_____ Other Surgeries: _____	

**List other practitioners involved in your care:**

First Name	Last Name	Specialty (MD/DO/NP)	Phone #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**New Patients Only – Please Complete This Section:**

**Past Medical History:**

Have you ever had any of the following tests?

No	Yes		Year	Results
		Colonoscopy		
		Flexible Sigmoidoscopy		
		Barium Enema		
		Upper GI / Barium Swallow		
		Upper Endoscopy		

**Family History:**

Have any blood relatives had any of the following:

No	Yes		Relationship (mother, brother, etc.) and age of diagnosis
		Colon Cancer	
		Colon Polyps	
		Ulcerative Colitis	
		Crohn's Disease	
		Irritable Bowel	
		Celiac Disease	
		Cancer of: (please circle) Uterus      Ovary Stomach    Pancreas Bile Duct   Small Intestine Urinary Tract (Kidney, Ureter)	

**Gastroenterology Specialists of Oregon, PC  
The Gastroenterology Endoscopy Center, Inc**

**Financial Policy**

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It is the policy of Gastroenterology Specialists of Oregon, PC (GSO) and The Gastroenterology Endoscopy Center, Inc is to have a Financial Policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

- New patients will be required to pay a deposit up to or equal to their deductible and co-insurance responsibility. This deposit will be applied towards the fees we charge the patient for our services. The exception will be on our contracted co-payment plans. We do require that you satisfy any co-payment at the time of your visit.
- Our Endoscopy Ambulatory Surgery Center participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance that we do not participate in, our office is happy to file the claim upon request; **however, payment in full is expected at time of service.**
- Payment for professional services can be made with cash, check or accepted credit card.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us prior to the visit.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be asked to sign a disclaimer indicating you will be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit.
- Our billing office is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company's Member Services Department. (The phone number is usually listed on the insurance card.)
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash or check at time of service has been verified.
- Effective in 2009, we will request only the last four digits of a patient's Social Security Number to assist with patient identification within our office. Only the last four digits are used because protection of your personal identity is important to us.
- For all unpaid balances over 90 days, the Endoscopy Center and/or GSO will apply FINANCE CHARGES at 1.0% per billing cycle (which equates to a 18% ANNUAL PERCENTAGE RATE). Unpaid balances are determined at the closing of your most recent account statement. All monies credited to your account prior to and including the statement closing date shall reduce your unpaid balance accordingly. The figure remaining after crediting all account payments is your unpaid balance, and finance charges shall be assessed against that figure as provided in this policy.

\_\_\_\_\_  
Initials of Patient or Responsible Party

\_\_\_\_\_  
Date

**Gastroenterology Specialists of Oregon, PC  
The Gastroenterology Endoscopy Center, Inc**

**BILLING RIGHTS SUMMARY**

**In Case of Errors or Questions About Your Bill**

If you think your bill is wrong, or if you need more information about a transaction on your bill, write us at 1508 Division Street, Suite 15, Oregon City, OR 97045, as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, please give us the following information:

1. Your name and account number.
2. The dollar amount of the suspected error.
3. Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are unsure about.

You do not have to pay any amount in question while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. While we investigate your question, we cannot report you as delinquent or take any action to collect the amount you question.

**Special Rule for Credit Card Purchases**

If you have a problem with the quality of goods or services that you purchased with a credit card, and you have tried in good faith to correct the problem with the merchant, you may not have to pay the remaining amount due on the goods or services. You have this protection only when the purchase price was more than \$50 and the purchase was made in your home state or within 100 miles of your mailing address.

**Non-Sufficient Funds Payments**

A service charge of \$25.00 will be assessed for all checks returned by your bank for non-sufficient funds or written on a closed account.

**Cancellation Policy**

I understand that if I want to cancel a **procedure** I must do so two working days prior, Monday through Friday. I understand I will be charged a **\$100.00** late cancellation fee if I fail to do so. This will be waived if one of our physicians determines that the procedure needed to be cancelled.

**Refund Statement**

Credit balances less than \$10.00 will be refunded by request only.

**Authorization of Claims Information**

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I authorize my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I authorize the insurance(s) and other payers, whose information I have provided, to pay and hereby assign directly to Gastroenterology Specialists of Oregon, PC and/or The Gastroenterology Endoscopy Center, Inc all benefits, if any otherwise payable to me for his/her services.

We are here to help you. Please sign that you have read and agree to this Financial Policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

# Gastroenterology Specialists of Oregon, P.C.

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Account Number: \_\_\_\_\_

## MESSAGE APPROVAL:

- Is it okay to leave a message at your **home**?      Yes    No    (circle one)
- Is it okay to leave a message at your **work**?      Yes    No    (circle one)
- Is it okay to leave a message on your **mobile**?      Yes    No    (circle one) \_\_\_\_\_

## PHARMACY INFORMATION:

Preferred Pharmacy Name & Location: \_\_\_\_\_

## ADVANCED DIRECTIVE INFORMATION: (Please Read Carefully & Select the Appropriate Box)

- NO, I do not have an Advanced Directive
- YES, I do have an Advanced Directive. *I DO NOT have a copy available for my chart.*
- YES, I do have an Advance Directive. *COPY ATTACHED for my chart.*

## EMERGENCY CONTACT INFORMATION: (Not Living With You)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

## RELEASE INFORMATION: (PLEASE READ THIS SECTION CAREFULLY)

- YES, I DO wish to have my medical or billing information released to the following person(s):

Spouse's Name: \_\_\_\_\_

Partner/Significant Others Name: \_\_\_\_\_

Relative's Name & Relationship to You: \_\_\_\_\_

- NO, I DO NOT wish to have medical or billing information released to any person(s), including those, if any, listed above.

(please initial) \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# Gastroenterology Specialists of Oregon, PC

## ACKNOWLEDGMENT AND CONSENT

I understand that the physicians of Gastroenterology Specialists of Oregon, PC and The Gastroenterology Endoscopy Center, Inc (referred to below as "this practice") will use and disclose health information about me, and this may include information created and received by this practice, it may be in written or electronic form, and may contain health history, status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that this practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, submit bills, claims, and related information to insurance companies, or others responsible for payment of my health care
- perform various office, administrative and business functions that support my physician's efforts to provide, arrange, and be reimbursed for quality, cost-effective health care

I also understand that this practice has a written description of how it will handle health information about me. This is a **Notice of Privacy Practices**, and describes uses and disclosures of health information, and the practices followed by employees or staff, and other office personnel of this practice, and my rights regarding this health information. **I have the right to review the Notice of Privacy Practices prior to signing this Acknowledgment and Consent form.** If this Notice of Privacy Practices is revised, I am entitled to receive a copy of the revised Notice. I also understand that notice of the revision and revised copy will be posted in the reception area at all offices, and on the web site at [www.gispecialists.org](http://www.gispecialists.org).

I understand that I have the right to restrict the use and disclosure of some or all of health information as described in the Notice of Privacy Practices, and I understand that this practice is not required by law to agree to such a request, in certain circumstances.

**By signing this form, I agree that I have reviewed and understand the information and above and I have received a copy of the Notice of Privacy Practices.**

By \_\_\_\_\_ Date \_\_\_\_\_

By \_\_\_\_\_ Date \_\_\_\_\_  
(Patient representative)

Description of Representative's authority: \_\_\_\_\_