NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Age _____ Birthdate_____

Race □ White □ African American □ Hispanic □ Asian □Other _____ □ Refuse to report

Ethnicity □ White □ African American □ Not Hispanic □Hispanic □Other_____ □Refuse to report

Language □ English □Hispanic □ Other _____ □ Refuse to report

Birth Sex: □ Male □Female □Transgender-female to male □Transgender Male-Female

Sexual Orientation: □Heterosexual (straight) □ Homosexual (lesbian/gay) □Bisexual □Decline to Specify

Address_____City/State/Zip_____

Social Security # _____ Married ____ Single _____ Divorced _____ Widowed _____

Home Phone _____ Cell Phone _____ Consent to text □ YES □ NO

Email address: _____

Employer _____ Work Phone (_____) _____ ext _____

Spouse's Name _____ Birth date _____ Social Security # _____

Cell number: _____ Employer _____ Work Phone _____

**May we speak to your spouse regarding your protected health information? ___ Yes ____ No

Who do you see in this office _____

WHO IS YOUR FAMILY DOCTOR? _____ Who referred you to our office: _____

Pharmacy Information

Pharmacy name _____ Phone # _____ City/Location_____

Mail in Pharmacy _____ Phone # _____ City/Location _____

Please **list names and contact phone numbers of people we have permission to speak to on your behalf:

_____

INSURANCE INFORMATION:

Primary Insurance _____
Who Carries the insurance_____
Date of Birth of insured _____

Secondary Insurance _____
Who Carries the insurance_____
Date of Birth of insured _____

I direct the insurer to pay to the physician, all benefits due him as a result of this claim. Although covered by the insurance, I am personally responsible for all charged. A photocopy of this authorization will be valid as the original.
Please be advised Dr. Cook/Dr. Horn and Dr. Bryson have ownership interest in Lake Cumberland Surgery Center, as do most of the physicians who work there. I am aware I may choose to have my procedure at the Lake Cumberland Regional Hospital or the Lake Cumberland Surgery Center.
I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.
Patient (or responsible party)

Signature of Patient/Parent/Guardian _____ Date _____

PATIENT QUESTIONNAIRE

Patient Name: _____ Birthdate: _____ Todays Date _____

Do you *Have* these symptoms:

CONSTITUTIONAL
Recent weight change _____No ____Yes
Fever _____No ____Yes
Fatigue _____No ___ Yes

EYES
Blurred Vision ____ No ____ Yes
Glaucoma ____ No ____ Yes

EARS, NOSE, MOUTH, THROAT
Hearing loss ____ No ____ Yes
Ringing in ears ____ No ____ Yes
Mouth sores ____ No ____ Yes

CARDIOVASCULAR
Chest Pain ____ No ____ Yes
Shortness of Breath ____ No ____ Yes
Swelling of ankles ____ No ____ Yes

RESPIRATORY
Chronic Cough ____No ____ Yes
Spitting up blood ____No ____ Yes
Wheezing ____ No ____Yes

GENITOURINARY
Burning with urination ____ No ____Yes
Blood in Urine ____ No ____Yes

MUSCULOSKELETAL
Joint pain or swelling ____ No ___ Yes
Back pain ____ No ___ Yes
Muscle pain ____ No ___ Yes

SKIN
Rash ___ No ____ Yes
Itching ___ No ____ Yes

GASTROINTESTINAL
Poor Appetite ____ No ___ Yes
Difficulty Swallowing ____ No ___ Yes
Heartburn ____ No ___ Yes
Nausea or Vomiting ____ No ___ Yes
Bloating ____ No ___ Yes
Belching ____ No ___ Yes
Regurgitation ____ No ___ Yes
Constipation ____ No ___ Yes
Diarrhea ____ No ___ Yes
Abdominal Pain ____ No ___ Yes
Change in bowel habits ____ No ___ Yes
Rectal bleeding ____ No ___ Yes
Black, tarry stools ____ No ___ Yes

NEUROLOGICAL
Headaches ____ No ___ Yes
Seizures ____ No ___ Yes
Strokes ____ No ___ Yes
Numbness ____ No ___ Yes

PSYCHIATRIC
Memory loss ____ No ___ Yes
Depression/Anxiety ____ No ___ Yes

ENDOCRINE
Heat or cold intolerance ____ No ___ Yes
Excessive thirst/urination ____ No ___ Yes

HEMATOLOGICAL
Bleeding or bruising tendency ____ No ___ Yes
Anemia ____ No ___ Yes
Past transfusion ____ No ___ Yes

Are you pregnant? ____ No ___ Yes

Which other medical **conditions/problems** do you have?

___ Hiatal Hernia	___ Asthma	___ Reflux	___ Barrett's Esophagus
___ Gastritis	___ Kidney Failure	___ Jaundice	___ Hepatitis
___ Kidney Stone	___ Polyps	___ Rheumatic Fever	___ Diverticulitis, irritable bowel
___ Ulcerative colitis	___ Crohn's disease	___ Physical disability	___ Ulcers
___ Diabetes	___ Hemorrhoids	___ High blood pressure	___ High cholesterol
___ Arthritis	___ Anxiety/Depression	___ Anemia	___ Cystic Fibrosis
___ Tuberculosis	___ Stroke	___ HIV	___ Mental Retardation

Other: _____

___ Heart conditions - ☐ stents placed; how many_____; by-pass ☐ yes ☐no ☐A-fib ☐Blood thinner _____
___ Pacemaker who is your cardiologist (Heart Doctor) _____

Have you ever smoked? ____ No ____ Yes Have you ever used alcohol? ___ No ___ Yes
# of packs per day _____ # of years _____ # of drinks per week? _____
When did you quit smoking? _____ When did you quit drinking?_____

Do you have a history of IV or other illicit drug use? ____ No ____ Yes What drug _____

Do you have allergies: ___ No ___ Yes _____

Do you have Drug allergies: ___ No ___ Yes _____

Are Immunizations up to date: ____ No ___ Yes

Do you have routine screening procedures? _____ No _____ Yes

Please list all medications (including over the counter, vitamins or herbal preparations), dosage and how long have you been taking the medicine: (You do not need to bring these with you when the list is complete)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you take Plavix, Coumadin, Aspirin, Xarelto, Effient or any other blood thinner? □ yes _____ □no
Who gives you a prescription for this type of medication? _____

PHARMACY NAME_____ TELEPHONE NUMBER_____

List all surgeries, endoscopies, x-rays and the ***year*** these were performed:

_____ _____
_____ _____
_____ _____
_____ _____

Have you ever experienced an adverse reaction to sedation or anesthesia? ___ No ___ Yes
If yes, for what procedure: _____
Do you have Malignant Hyperthermia? ___ No ___ Yes

FAMILY HISTORY – Please check all that apply to your family history -

	Father	**Mother**	**Siblings**	**Other**
Colon Cancer	_____	_____	_____	_____
Colon Polyps	_____	_____	_____	_____
Ulcers	_____	_____	_____	_____
Uterine/Endometrial/ Ovarian Cancer	NA	_____	_____	_____
Liver Disease	_____	_____	_____	_____

Gastroenterology Associates of Lake Cumberland
(606) 677-2913 Fax: (606)677-6983

Authorization for Release of Information

Signed authorization is necessary to release or obtain medical records. By signing this authorization you are giving Gastroenterology Associates of Lake Cumberland permission to release/obtain medical records pertinent to your continued care.

Patient Name: _____
First Middle Initial Last Maiden or Other Name
Date of Birth: _____ SS: _____

Address: _____
Street address City, State and Zip Code
Day Phone _____ Evening phone _____

I hereby authorize Gastroenterology Association of Lake Cumberland to ***obtain*** information from my medical record from _____as indicated below to:

☐Information to be released or requested may include:

☐History and Physical exam
☐Progress Notes
☐Lab reports
☐X-ray reports
☐Operative note and Pathology
☐Substance Abuse including alcohol/drug abuse
☐Mental Health including psychotherapy notes
☐HIV related information (AIDS related testing)
☐Other_____
☐All Records

I authorize Gastroenterology Associates of Lake Cumberland to ***release*** information from my medical record to:
_____.

I request my records to be ☐faxed to _____ ☐electronically sent ☐pick up/mail paper copy

Purpose of Disclosure: ☐Continued Care ☐Consultation/second opinion ☐ Insurance
☐Changing Physicians ☐ Legal ☐Other (Please specify) _____

I understand this authorization will expire in one year. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

I understand that I am being requested to release this information by Gastroenterology Associates of Lake Cumberland for the purpose of medical care. By authorizing this release on information, my health care and payment for my health care will not be affected if I do not sign this form.

I understand I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

I have been informed that Gastroenterology Associates of Lake Cumberland will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

I understand that in compliance with Kentucky statute, I will pay the fee for such records. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____
Signature of Patient or legal guardian Date

Gastroenterology Associates of Lake Cumberland
56 Tower Circle
Somerset, KY 42503
606-677-2913
606-677-6983 fax

Our physicians have privileges at Lake Cumberland Regional Hospital and Lake Cumberland Surgery Center. Dr. Cook, Dr. Horn and Dr. Bryson have ownership interest in Lake Cumberland Surgery Center as do most physicians that work there. You may schedule procedures at either facility.

When you are scheduled for a procedure; your DRIVER must NOT leave the premises.

If you cannot keep your procedure appointment, please cancel at least 48 hours before it is scheduled. Other patients can use this time.

Your signature below ensures you have read the above policies.

Thank you,

_____	_____	_____
Signature of patient/guardian	Printed name	Patient Date of Birth

Medicare Secondary Payer Questionnaire

(Short Form)

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. Are you receiving benefits from any of the following programs?

Black Lung	☐YES (Long form Part I)	☐NO
Research Grant	☐YES (Long form Part I)	☐NO
Veteran Affairs	☐YES (Long form Part I)	☐NO

2. Was illness/injury due to a work related accident/condition?

☐YES ☐NO

If **YES,** answer the following:

☐Work related accident (complete Part I of long form).

☐Non-work related accident (complete Part II of long form).

3. Is the patient currently employed?

☐YES (answer next question) ☐ NO

Do you have group health plan (GHP) coverage? If yes, are there under or over 20 employees?

☐OVER (Long form Part IV) UNDER

4. Is the patient's spouse currently employed?

☐YES (answer next question) ☐NO

Does your spouse have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
OVER (Long form Part IV) UNDER

5. Is the patient entitled to Medicare benefits as a result of:

Age _____

End Stage Renal (Kidney) Disease? ☐YES (Long form part VI) ☐NO

Disability? ☐YES (Long form part V) ☐NO

6. Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required, ALERT: If yes bill SNF not Medicare)

☐YES ☐NO

I confirm that the above information if correct.

Patient Name: _____ Date: _____

Patient Signature: _____

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdF

Clinic

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

P

The patient understands that:

_____ (please initial) The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION: I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S): Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. EMAIL AND TEXT COMMUNICATIONS: If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. FINANCIAL POLICY: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PARTICIPATION IN HEALTH INFORMATION EXCHANGE: Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that my include but not be limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as my be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic Website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

VIII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____