Gastroenterology Associates
1249 Ambler Ave, Ste 200
Abilene, Texas 79601
Phone (325) 677-2626 Fax (325) 455-7647

Gary Roark, M.D. William Haynes, M.D. Illiana Carpenter, PA-C

Authorization for Release of Health Information

From: _____ **To:** _____

Phone #: _____ **Phone #:** _____

Fax #: _____ **Fax #:** _____

INFORMATION REQUESTED:

_____ **All Records** _____ **H&P** _____ **Office Notes**

_____ **Colonoscopy/ EGD Reports** _____ **Labs** _____ **Radiology Reports**

REASON FOR INFORMATION BEING RELEASED: _____

HIV/AIDS: I consent to the release of any positive or neative test results for AIDS or HIV infection, Antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

INITIAL: _____ **DATE:** _____

This authorization will expire after 180 days or _____.

Notice to Patient or Patient's Representative

1.) I understand that this authorization is voluntary, that I may refuse to sign this authorization, and that I have the right to revoke this authorization in writing.
2.) I understand that health care or payment forhealth care will not be affected if I do not sign this authorization.
3.) I understand that the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and that it may no longer be protected by HIPAA privacy regulations.

_____ _____

Signature of Patient/Legal Guardian **Print Name**

_____ _____ _____

Date of Birth **SSN** **Today's Date**

GASTROENTEROLOGY ASSOCIATI
1249 AMBLER AVE, SUITE 200
ABILENE, TX 79601
(325) 677-2626

ABILENE ENDOSCOPY CENTER
1249 AMBLER AVE, SUITE 100
ABILENE, TX 79601
(325) 677-2626

NAME: _____

DOB: _____

SSN#: _____

List person(s) you want to allow access to your confidential medical care information and payment for your care.

1 _____ _____
(Relationship)

2 _____ _____
(Relationship)

Please check all that apply:

_____ **Only information that pertains to my appointment time.**

_____ **Information concerning my health care payment for care.**

I, _____, give permission to the above listed person(s) to my confidential medical information. I understand that this information may be given in the office or via telephone.

_____ _____
Patient Signature **Date**

NEW PT _____ **PROVIDER**_____ DATE _____

EST PT _____ HT _____

GASTROENTEROLOGY ASSOC. LLP WT _____

RM # _____ **HISTORY QUESTIONNAIRE** B/P _____

BMI _____

PT NAME _____ DOB _____ AGE _____

PT PRIMARY DR. _____ REF. DR. _____

1.) WHY ARE YOU SEEING THE DR. TODAY?

_____

_____

_____

_____

2.) MEDICAL HISTORY:

_____

_____

_____

_____

3.) MEDICATIONS TAKEN DAILY WITH DOSAGE AND HOW OFTEN:
(INCLUDING OVER THE COUNTER)

4.) ARE YOU ON A BLOOD THINNER? YES NO IF YES, WHICH ONE: _____

5.) ARE YOU ALLERGIC TO ANY MEDICATION? YES NO **IF YES, WHICH ONE(S) AND WHAT REACTION DO YOU HAVE?**

_____

_____

6.) HAVE YOU HAD A FLU SHOT? YES____ NO____

7.) WHEN WAS YOUR LAST COLONOSCOPY? _____ EGD? _____

8.) DO YOU SMOKE? YES____ NO ____ IF SO, HOW MUCH? _____

DO YOU USE SMOKELESS TOBACCO? YES____ NO ____ VAPE? YES____ NO ____

DO YOU DRINK ALCOHOL? YES____ NO____ IF YES, HOW MUCH? _____

DO YOU DRINK CAFFEINE? YES____ NO ____

DO YOU EXERCISE? YES____ NO____

9.) ILLICT DRUG USE: (includ. Marijuana) YES____ NO____ HAVE YOU USED IN THE PAST? YES____ NO____

GASTROINTESTINAL

__Y__N Colon Polyps
__Y__N Colon Cancer
__Y__N Constipation
__Y__N Chrohn's Disease
__Y__N Diarrhea
__Y__N Diverticulosis
__Y__N Esophageal
__Y__N Gallbladder Disease
__Y__N Hepatitis
__Y__N Hiatal Hernia
__Y__N Capsule Endoscopy YR_____
__Y__N Imaging Studies (past 6 months)
__Y__N Sigmoidoscopy YR_____
__Y__N IBS- C__ D__
__Y__N Liver Disease
__Y__N Ulcerative Colitis
__Y__N Upper GI Bleed

PAST SURGICAL CENTER

__Y__N Appendectomy
__Y__N Back Surgery
__Y__N Cataract Surgery
__Y__N Coronary Artery Bypass (CABG)
__Y__N Colectomy-LSC Total
__Y__N Gallbladder Surgery
__Y__N Gastric Surgery
__Y__N Gastrointestinal Surgery
__Y__N Hermorrhoidectomy
__Y__N Hernia Repair
__Y__N Hernia Repair-Inguinal
__Y__N Hysterectomy-Total Abdominal
__Y__N Hysterectomy- Laparoscopic Vaginal
__Y__N Knee Replacement Rt__Lt__
__Y__N Phayrnx, Adenoids, Tonsils-Surgery
__Y__N TURP
__Y__N Ulcer Surgery
__Y__N Pacemaker
__Y__N Defibrillator

GENERAL MEDICAL CONDITIONS

__Y__N Asthma
__Y__N Anemia
__Y__N Cariovascular Disease
__Y__N Congestive Heart Failure
__Y__N Coronoary Artery Disease
__Y__N Depression
__Y__N Diabetes Mellitus
__Y__N Elevated Liver Enzymes
__Y__N Heartburn
__Y__N Hyperlipidemia
__Y__N Kidney Problems
__Y__N Kidney Stones
__Y__N Pancreatic Disease
__Y__N Pulmonary Disease

__Y__N Anxiety
__Y__N Arthritis
__Y__N COPD
__Y__N Glaucoma
__Y__N HIV Positive
__Y__N High Blood Pressure
__Y__N Juandice
__Y__N Pneumonia
__Y__N STD
__Y__N Thyroid Disease
__Y__N Vascular Disease
__Y__N Cancer, Type_____
__Y__N Hospitalizations (in past 30 days)

FAMILY HISTORY

__Y__N Breast Cancer
__Y__N Colon Polyps
__Y__N Colon Cancer who in family?

_____

__Y__N Thyroid Disorder
__Y__N Ovarian Cancer
__Y__N Other Cancer
__Y__N Depression
__Y__N Prostate Cancer
__Y__N Early Deaths
__Y__N Heart Disease

__Y__N High Blood Pressure
__Y__N Liver Disease

__Y__N Kidney Disease
__Y__N Allergies
__Y__N Diabetes
__Y__N GI Disorders
__Y__N Stroke
__Y__N Bleeding Tendency
__Y__N Anxiety

FAMILY HISTORY WITH THE FOLLOWING: (Circle Who)

Cancer	Mother	Father	Sister	Brother
Diabetes	Mother	Father	Sister	Brother
Heart Disease	Mother	Father	Sister	Brother
Hypertension	Mother	Father	Sister	Brother
Stroke	Mother	Father	Sister	Brother
Other	Mother	Father	Sister	Brother

OTHER'S NOT LIST: _____

GARY ROARK, MD
WILLIAM C. HAYNES, MD
ILIANA CARPENTER, PA-C

Gastro-Enterology SM
Gastroenterology Associates, L.L.P.

PLEASE PRINT ALL INFORMATION

APPOINTMENT DATE: _____APPOINTMENT TIME: _____
PATIENT'S NAME: _____D.O.B:_____ AGE: _____ SEX: _____
SOCIAL SECURITY NUMBER: _____ EMAIL: _____
NAME OF PARENT OR GUARDIAN (IF PATIENT IS YOUNGER THAN 18) _____
NAME OF PERSON(S) RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT) _____
MAILING ADDRESS: _____ APT#:_____
CITY, STATE, ZIP: _____HOME PHONE: (_____)_____
BUSINESS PHONE: (_____)_____ EMPLOYER:_____
BUSINESS ADDRESS: _____

FINANCIALLY RESPONSIBLE PERSON(S):

DRIVER'S LICENSE#: _____ STATE:_____ WE WILL ASK TO MAKE A COPY OF YOUR LICENSE
PRIMARY INSURANCE: _____ SECONDARY: _____
NAME OF INSURED: _____ D.O.B:_____ S.S.#:_____
MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? YES NO

PLEASE LIST PERSON(S) WITH WHOM WE CAN DISCUSS YOUR MEDICAL INFORMATION:
1._____ 4._____
2._____ 5._____
3._____ 6._____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
HOME PHONE: (_____)_____BUSINESS PHONE:(_____)_____
REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____
OTHER PHYSICIANS TREATING YOU: _____

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO REFERRING DOCTOR AND/OR ANY DOCTOR PER **GASTROENTEROLOGY ASSOCIATES**. I AUTHORIZE MY FAMILY OR REFERRING DOCTOR TO RELEASE MY RECORDS TO DR. HAYNES/DR. ROARK/DR. SMITH. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND REQUEST PAYMENTS OF BENEFITS BE MADE TO **GASTROENTEROLOGY ASSOCIATES**.
I HEREBY AFFIRM THAT ALL THE INFORMATION PROVIDED BY ME IS TRUE TO THEBEST OF MY KNOWLEDGE, AND WILL ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT WITH **GASTROENTEROLOY ASSOCIATES**.

AUTHORIZED SIGNATURE: _____S.S#:_____ D.OB.#_____
RELATIONSHIP TO PATIENT: _____

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Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and our practice we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our Practice Administrator. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Office Visits-

- If you do not have insurance, payment is due at the time of service. Uninsured new patients are required to pay at the time of the first visit, which will be collected when you arrive for your appointment.
- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. It is the policy of our office to collect this co-payment when you arrive for your appointment.
- In the event that your health plan determines a service to be "not covered" or you have an insurance plan for which we do not have prior agreement, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient, parent or guardian with custody of payment.

Procedure Services-

- We will bill your health plan for all procedures (Doctor's fee, Professional fee for procedure). We will verify coverage and benefits and obtain any required prior authorization. If you cannot pay the full amount, you must make payment arrangements with the Practice Administrator prior to the procedure. Any balance due after insurance payment is your responsibility and is due upon receipt of a statement from our office.
- You may receive bills from separate entities associated with your procedure, such as the physician, facility, pathologist, laboratory and/or anesthesia. If Propofol is used, you will receive a separate anesthesia bill. We can only provide you with information for the physician's fee.

***Please Note: Fees are subject to change if a biopsy/polyp is performed.**