LOWCOUNTRY GASTROENTEROLOGY ASSOCIATES, PA

Established Patient Form

Name: _____ SS#: _____

Address: _____ City/State: _____ Zip: _____

Home #: _____ Work #: _____ Cell#: _____

Sex: ____ Race: ____ DOB: _____ Primary Care Doctor: _____

Employer: _____ Marital Status: ____ Spouses Name: _____

Providing your email is important in order to access our patient portal. The portal is a valuable way for you to actively participate in your healthcare.

Email Address: _____

Name & Location of your pharmacy: _____

IN CASE OF EMERGENCY

Emergency Contact: _____

Relation: _____ Contact #: _____

I hereby authorize Lowcountry Gastroenterology Assoc. PA to discuss any matters related to my medical treatment and/or payment for services rendered with the following persons:

1. _____ Contact #: _____
2. _____ Contact #: _____

Have you ever seen a Gastroenterologist before? Y or N

- If yes, then you may need to sign a medical release so the physician can review those records.

We leave messages (i.e. appointment reminders, biopsy results, etc.) on the answering machine or voicemail of the telephone numbers given by you. Unless otherwise specified, we also may leave messages with your spouse. If you do NOT want these messages left, please indicate and tell the office staff member at the reception window.

AUTHORIZATION

I hereby authorize for my health information to be included in the Community Health Exchange program. (*EHX)*

(This authorization allows your records at our practice to be shared with any of your Roper or East Cooper doctors.)

Signature: _____ Date: _____

I hereby consent treatment by the providers and/or associated of Lowcountry Gastroenterology Associates P.A.

Signature: _____ Date: _____

I hereby acknowledge that I have reviewed a copy of Lowcountry Gastroenterology Associates, PA's Notice of Privacy Policies and Practices. These policies are in the white notebook in the waiting area of our office.

Signature: _____ Date: _____

MEDICATION LIST

Please fill out all of your medications currently

Name: _____ Date: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

PLEASE LIST ALL MEDICATION & FOOD ALLERGIES: (ie: eggs) & REACTIONS:

1. _____ 2. _____

3. _____ 4. _____

COMPLAINT FOR TODAY'S VISIT

_____

_____

_____

LOWCOUNTRY GASTROENTEROLOGY FINANCIAL POLICY

Welcome to LCGI. In order to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of the guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

1. We ask that you present you insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address phone number, or employer, please notify the receptionist.
3. We will collect your deductible, co-pay, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for payment. We accept, cash, check and all major credit cards.
4. If we do not participate with your insurance company, you will be expected to make a payment in full at the time services are rendered.
5. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and to be reported to one or more credit bureau(s).
6. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have supplemental insurance, we will also bill that for you. We then will bill you once the supplemental has been processed.
7. COMMERCIAL INSURANCE PATIENTS: We will bill your insurance for you; however your co-pays will be collected at the time of the service, NO EXCEPTIONS. If your insurance requires an authorization to see a specialist, it will be your responsibility to obtain that authorization.
8. SELF PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you are unable to pay in full; you must call our billing department PRIOR to seeing the physician to make payment arrangements.
9. NO SHOW OR MISSED APPOINTMENTS: When an appointment is scheduled with the physician, time is specifically allotted for you. When an appointment is not cancelled in advance, and the patient "NO SHOWS" another patient is unable to be moved into that slot. We understand that there may be times when you are unable to keep your appointment, but we ask for you to give us a courtesy call to cancel your appointment. If TWO appointments are missed without cancellation, you will be charged a $25.00 fee. If THREE appointments are missed, you will be dismissed from the practice for non-compliance.
10. Your insurance is a contract between you, your employer and the insurance company. WE ARE NOT A PARTY TO THAT CONTRACT. It is very important that you understand the provisions of your policy. We cannot guarantee payments of all claims. If your insurance company pays only a portion of the bill of rejects your claim, any contact or explanation should be made to you, there policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department. (843)884-5200

I have read and have full understanding of the financial policy of Lowcountry Gastroenterology.

Signature:_____ Date:_____