DIGESTIVE HEALTH CENTER, PA

PEDIATRIC PATIENT INFORMATION

PATIENT

First Name (as appears on insurance card)	Middle Name	Last Name	(Jr, III, IV...)

Preferred Name	Age	Date of Birth	Sex: ☐ M ☐ F ☐ _____	Social Security Number

Street Address	City	State	Zip Code

Mailing Address (if different) or P.O. Box	City	State	Zip Code

Cell Phone ☐ *preferred*	Home Phone ☐ *preferred*	Primary E-mail address

Race: ☐ White ☐ Asian ☐ Native American or Alaska Native ☐ Black or African American ☐ Unknown ☐ _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Preferred Language (if not English): | Do you need an interpreter? ☐ Yes ☐ No

MOTHER ☐ Guarantor/ Person Financially Responsible ☐ Mother's HOME address SAME AS PATIENT

Name	Social Security Number	Street Address	City	State	Zip Code

Employer	Occupation	Employer Street Address	City	State	Zip Code

Cell Phone ☐ *preferred*	Home Phone ☐ *preferred*	Work Phone	Primary E-mail address

FATHER ☐ Guarantor/ Person Financially Responsible ☐ Father's HOME address SAME AS PATIENT

Name	Social Security Number	Street Address	City	State	Zip Code

Employer	Occupation	Employer Street Address	City	State	Zip Code

Cell Phone ☐ *preferred*	Home Phone ☐ *preferred*	Work Phone	Primary E-mail address

LEGAL GUARDIAN ☐ Guarantor/ Person Financially Responsible ☐ Legal Guardian's HOME address SAME AS PATIENT

Name	Social Security Number	Street Address	City	State	Zip Code

Employer	Occupation	Employer Street Address	City	State	Zip Code

Cell Phone ☐ *preferred*	Home Phone ☐ *preferred*	Work Phone	Primary E-mail address

EMERGENCY CONTACT (someone not living with the patient)

Name	Relationship	Street Address, City, State, Zip	Primary Phone ☐ Cell ☐ Home ☐ Work

Primary Care Provider (PCP): | Referring Provider (if different from PCP):

INSURANCE *Complete this section ONLY if you do not have insurance card(s) with you

PRIMARY Insurance Provider	Insurance Company: Street Address, City, State, Zip	Group NAME	Group NUMBER

Policy Holder Name (as appears on insurance card)	Date of Birth	Relationship to patient	Policy Number

SECONDARY Insurance Provider	Insurance Company: Street Address, City, State, Zip	Group NAME	Group NUMBER

Policy Holder Name (as appears on insurance card)	Date of Birth	Relationship to patient	Policy Number

We will ask you to update this information every 12 months
Please make us aware if there are changes prior to your annual update

CLINIC – PHYSICIAN – PATIENT ARBITRATION AGREEMENT

_____("Patient"), engages Gastrointestinal Associates and Endoscopy Center or employee thereof, and each Physician that renders medical care and services to perform services in conjunction with Patient's medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to, patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative of Patient, as the case may be, and the Gastrointestinal Associates and Endoscopy Center and each Physician individually, where the claim or the amount in controversy exceeds $5,000, such dispute or controversy shall be submitted to JAMS (Judicial Arbitration and Mediation Services, Inc.), or it successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of $5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in-person hearing in his or her county in accordance with the Federal Arbitration Act. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties agree to be bound by the arbitrator's decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgment may be entered on the arbitrator's award, if any, by any court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act, and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than $125.00, with Gastrointestinal Associates and Endoscopy Center bearing the other arbitration costs.

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if Patient is a minor or incapacitated. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this Arbitration Agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

SIGNATURE OF PATIENT/GUARDIAN

By: _____ Date: _____

For Office Use Only

Witness Signature: _____ Date: _____

DIGESTIVE HEALTH CENTER, PA

Patient Interview Form
Pediatrics

20171121

Patient Information

Name:_____ **Date of Birth:** _____

Reason for visit: _____

Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino _____ Patient declines to specify

Race: _____White _____ Black or African American _____Asian _____ Native American or Alaska Native

_____Unknown _____Patient declines to specify

Sex: _____ Male _____Female

Allergies NOTE: Include reaction for each

_____ No known allergies		_____ No known drug allergies	
_____ Penicillins	_____ Morphine IV	_____ Demerol	___ Latex
_____ Soy	_____ contrast	_____ Codeine Sulphate	___ Tape
_____ Dilaudid	_____ Milk	_____ Seafood	___ Eggs
_____ Sulpha (Sulfonamides)		_____ Other	_____

Allergic Reaction(s) _____

Current Medications *(Please list pharmacy even if you are not currently taking any medications)*

_____ None **Pharmacy:** _____ *(Walgreens, Rite-Aid, etc.)* **Location:** _____ *(Flowood, Madison, State St., etc.)*

I consent to obtaining a history of my medications purchased at pharmacies: ◯Yes ◯ No

Name	Strength	How taken? / Frequency?

◯ I needed more space and wrote on the back of this page

Immunizations

_____None

_____Influenza When:_____	_____ Hepatitis A When:_____	_____ Hepatitis B When:_____	_____ Shingles When:_____	_____ Pneumonia When:_____
_____ SARS-CoV-2 Vaccination (COVID-19) When:_____				

Diagnostic Studies / Tests

_____ None

_____Colonoscopy When:_____	_____ EGD When:_____	_____ EUS When:_____	_____ ERCP When:_____	_____Sigmoidoscopy When:_____
_____Capsule Endoscopy When:_____		_____PEG tube placement When:_____		_____EGD / Dilation When:_____

Medical Conditions

	Acid Reflux/GERD		Alcohol Abuse		Anal Fissure		Barrett's Esophagus
	Bowel Obstruction		C. Diff		Cirrhosis		Crohn's Disease
	Chronic Constipation		Celiac Disease / Sprue		Colitis / Ulcerative Colitis		Colon Polyps
	Diverticulitis		Diverticulosis		Duodenal Ulcer		Eating Disorder
	Esophageal stricture/narrowing		Esophageal varices		Gallbladder problems		Gastrointestinal bleeding
	H. Pylori Infection		Hemorrhoids		Hepatitis A		Hepatitis B
	Hepatitis C		Intestinal infection		Irritable bowel syndrome (IBS)		Jaundice (yellow skin)
	Liver Failure		Pancreatitis		Stomach Ulcer		
	Abnormal heartbeat		Alzheimer's		Anemia		Antibiotic treatment within last 2 months
	Anxiety		Arthritis		Asthma		Autoimmune disease
	Bleeding disorder		Blood clots		COPD		Congestive heart failure
	Dementia		Depression		Diabetes		Dialysis
	Emphysema		Fibromyalgia		Glaucoma		GYN
	Heart attack		Heart disease		High blood Pressure		High cholesterol / Triglycerides
	HIV exposure		HIV positive		Implanted devices		Kidney disease
	Malignant hyperthermia		Mental illness		Physical or sexual abuse (Child)		Physical or sexual abuse (Adult)
	Prostate		Seizure disorder		Sleep apnea		Multiple sclerosis
	Stroke		TB		Thyroid disease		
	Mouth/Throat Cancer		Esophageal Cancer		Stomach Cancer		Pancreatic Cancer
	Blood Cancer (e.g. Leukemia)		Uterine Cancer		Ovarian Cancer		Skin Cancer
	Breast Cancer		Lung Cancer		Colon Cancer		Prostate Cancer
	Other						

Previous procedures

_____ None		Has patient ever been hospitalized? When:_____		
_____Adhesions When:_____	_____ Aortic Aneurysm When:_____	_____ Appendix When:_____	_____ Back When:_____	_____Bariatric (weight loss) When:_____
_____Brain When:_____	_____ Breast When:_____	_____ Carpal Tunnel When:_____	_____ Colon When:_____	_____Coronary stent When:_____
_____C-Section When:_____	_____ Defibrillator placement When:_____	_____ Esophagus When:_____	_____ Gallbladder When:_____	_____Heart bypass When:_____
_____Heart valve When:_____	_____ Hemorrhoids When:_____	_____ Hernia When:_____	_____ Hysterectomy When:_____	_____Joint replacement When:_____
_____Laparoscopy When:_____	_____ Pacemaker When:_____	_____ Prostate When:_____	_____ Rotator cuff When:_____	_____Stomach When:_____
_____Tonsils When:_____	_____ Transplant When:_____	_____ Tubal Ligation When:_____	_____ Ulcer When:_____	

Social History

Marital Status

___ **Married** _____ **Single** _____ **Divorced** _____ **Widowed**

Alcohol

___ **None** _____ **In the past**

___ **Current Daily** _____ **Current Weekly** _____ **Current Monthly** _____ **Occasional**

Tobacco Smoking Status

___ **Current Every Day** _____ **Current Some Day** _____ **Former Smoker** _____ **Never**

___ **Smoker, current status unknown** _____ **Light tobacco smoker**

___ **Unknown if ever smoked** _____ **Heavy tobacco smoker**

Drug Use

___ **None**

___ **Uses IV drugs currently** _____ **Used IV drugs in the past** _____ **Recreational Drug Use**

Review of Systems

Gastrointestinal

None	Yes
Abdominal pain	
Anorectal pain / Itching	
Bloating / Gas	
Blood in stool	
Change in bowel habits	
Constipation	
Diarrhea	
Incontinence of stool	
Heartburn / Reflux	
Difficulty swallowing	
Nausea	
Vomiting	
Black tarry stools	

Genitourinary

None	Yes
Dark urine	
Heavy menstration	
Pregnancy	
Frequent urination	
Blood in urine	
Urinary incontinence	

Integumentary

None	Yes
Itching	
Jaundice	
Rashes	

Cardiovascular

None	Yes
Heart murmur	
Irregular heart beat	
Peripheral edema	
Palpitations	
Chest pain	

Neurological

None	Yes
Frequent headaches	
Memory loss / Confusion	
Numbness or tingling	

Endocrine

None	Yes
Cold intolerance	
Excessive thirst	

Constitutional

None	Yes
Fatigue	
Fever	
Loss of appetite	
Night sweats	
Weight gain	
Weight loss	

Psychiatric

None	Yes
Anxiety	
Depression	

ENMT

None	Yes
Vision problems	
Eye pain / irritation	
Sore throat	
Hoarseness	
Mouth sores	

Hematologic/Lymphatic

None	Yes
Easy bruising	
Prolonged bleeding	
Enlarged / painful lymph nodes	

Musculoskeletal

None	Yes
Back pain	
Joint pain	

Respiratory

None	Yes
Frequent cough	
Snoring	
Sleep apnea	
Wheezing	
Shortness of breath	

Allergic/Immunologic

None	Yes
Medication allergies	
Food allergies	
Seasonal allergies	

Family History

Diagnosis	Age @ diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Other
Brain Cancer								
Colon Cancer								
Kidney Cancer								
Ovarian Cancer								
Prostate Cancer								
Pancreatic Cancer								
Small Bowel Cancer								
Stomach Cancer								
Urinary Tract Cancer								
Uterine (Endometrial) Cancer								
Stomach Problems								
Celiac Disease								
Crohn's Disease								
Colon Polyps								
Liver Disease								
Ulcerative Colitis \ IBD								

PATIENT AUTHORIZATION FORM

INFORMED CONSENT FOR EVALUATION, DIAGNOSIS AND TREATMENT

I am seeking the diagnostic services, care, treatment, and possible procedures through the providers and the staff of Digestive Health Center. I hereby authorize Digestive Health Center to examine me and render medical or surgical care, as they deem necessary.

When the practice of medicine is carried out with the best intentions, at times the outcomes may be less than optimal with significant adverse events or possible side effects occurring. These include but are not limited to missed diagnoses, missed cancers, failure to determine the correct diagnosis, adverse effects from medications and procedures, loss of normal health, and even the possibility of death. I understand that even when practicing medicine in good faith the physicians and attending staff at Digestive Health Center may perform evaluations and treatments with less than optimal outcomes. This is an understood risk involved in medical care.

_____ I consent to individuals not employed by Digestive Health Center be present for educational purposes to observe care rendered to me.

_____ I have been informed and understand that this facility is affiliated with a teaching institution, and the procedures performed may require observation, cooperation, and services of multiple healthcare providers. I authorize residents and/or students to participate in my care as directed and supervised by my gastroenterologist.

_____ In the event any individual is exposed to my blood or body fluids, I consent for testing to determine the presence of infectious diseases such as Hepatitis B, Hepatitis C, HIV, etc. The results of these tests shall be confidential.

_____ I consent to being enrolled in the E-Prescribe Program, per the Medicare Modernization Act (MMA) of 2003. I agree that Digestive Health Center can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_____ I have been provided with a copy of **"Patients' Bill of Rights and Responsibilities."**

Signature of Patient or Legal Guardian _____ Date _____

Witness _____ Date _____

Relationship to Patient _____

FINANCIAL POLICY AND INSURANCE ASSIGNMENT OF BENEFITS

Digestive Health Center provides services on a fee-for-service basis. The responsibility for payment of fees for services is the direct obligation of the patient. Any financial payment a patient may receive from private insurance or government agencies is a matter strictly between the patient and the insurance carrier or government agency. Our physicians are participating Medicare physicians and do accept assignment on Medicare patients, but any deductible or co-payment is the patient's responsibility. The same responsibility exists for HMOs or PPOs our physicians participate in. Our staff will provide assistance if needed with your insurance inquiries.

Patients seen at Digestive Health Center will receive separate bills from the Physician, the Facility, and any services rendered such as pathology, anesthesia, lab services, and radiology.

The fees for care during hospitalizations or for specialized procedures can be paid on a payment plan. Extra insurance forms, letters to lawyers, etc. will necessitate an extra fee due to additional paperwork and time involved.

As a patient of Digestive Health Center you agree that payment of authorized Medicare, Tricare, or any other insurance benefit be made to the provider of Digestive Health Center for any services furnished by that physician, provider, or facility.

As a patient of our physician, provider, or facility, you authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services, Tricare, or any other insurance company and its agents any information needed to determine these benefits or the benefits payable to related services.

Financial Responsibility: As a patient of my physician, the facility, and any services rendered such as pathology, anesthesia, lab, or radiology services, I understand and agree that if any part of my account is not paid by insurance, I am solely financially responsible.

Signature of Patient or Legal Guardian _____ Date _____

Witness _____ Date _____

Relationship to Patient _____

SELF-PAY AGREEMENT

The Self-Pay Agreement is intended to provide Self-Pay patients/legal guardians with an understanding of the financial aspect of healthcare services provided at Digestive Health Center. Self-Pay patients/legal guardians should read this agreement carefully before making a decision and proceeding with care.

- Self-Pay patients/legal guardians will receive a bill from Digestive Health Center for healthcare services provided by Digestive Health Center.
- A Self-Pay Agreement must be signed for each Digestive Health Center account for which it applies.
- Self-Pay patients/legal guardians will be required to make a minimum deposit at the time of service.
- The patient/legal guardian will be responsible for full payment of charges.
- Digestive Health Center will not bill any insurance plan at a later date if the Patient/Legal Guardian elects to be Self Pay at the time of service.

DIGESTIVE HEALTH CENTER, PA

Signature of Patient or Legal Guardian _____ Date _____

Witness _____ Date _____

Relationship to Patient _____