Midwest Gastrointestinal Associates PC

Welcome to Midwest Gastrointestinal Associates, PC

Dear Patient:

An appointment has been scheduled for you on _____

with Doctor_____ at

17001 Lakeside Hills Plaza, Suite 200
Omaha, NE 68130
(map on reverse)
Phone (402) 885-8700
Fax (402) 397-6656

Please arrive for your appointment at _____ am/pm.

Your appointment is scheduled at _____ am/pm.

In an effort to make the registration process more efficient, please bring the following items to your appointment:

- Completed Midwest GI History Form (enclosed). This form contains valuable information and will assist the doctor in your care.
- Your insurance card(s) and photo ID.
- A list of your medications (to include prescription and over-the-counter), vitamins, supplements and herbs along with the dosage, and how often you take them.
- Signed Midwest GI Financial Policy (enclosed). It is important to us that you understand our policy so please read this carefully and if you have questions, do not hesitate to ask.
- Co-pay is expected to be paid at the time of service.

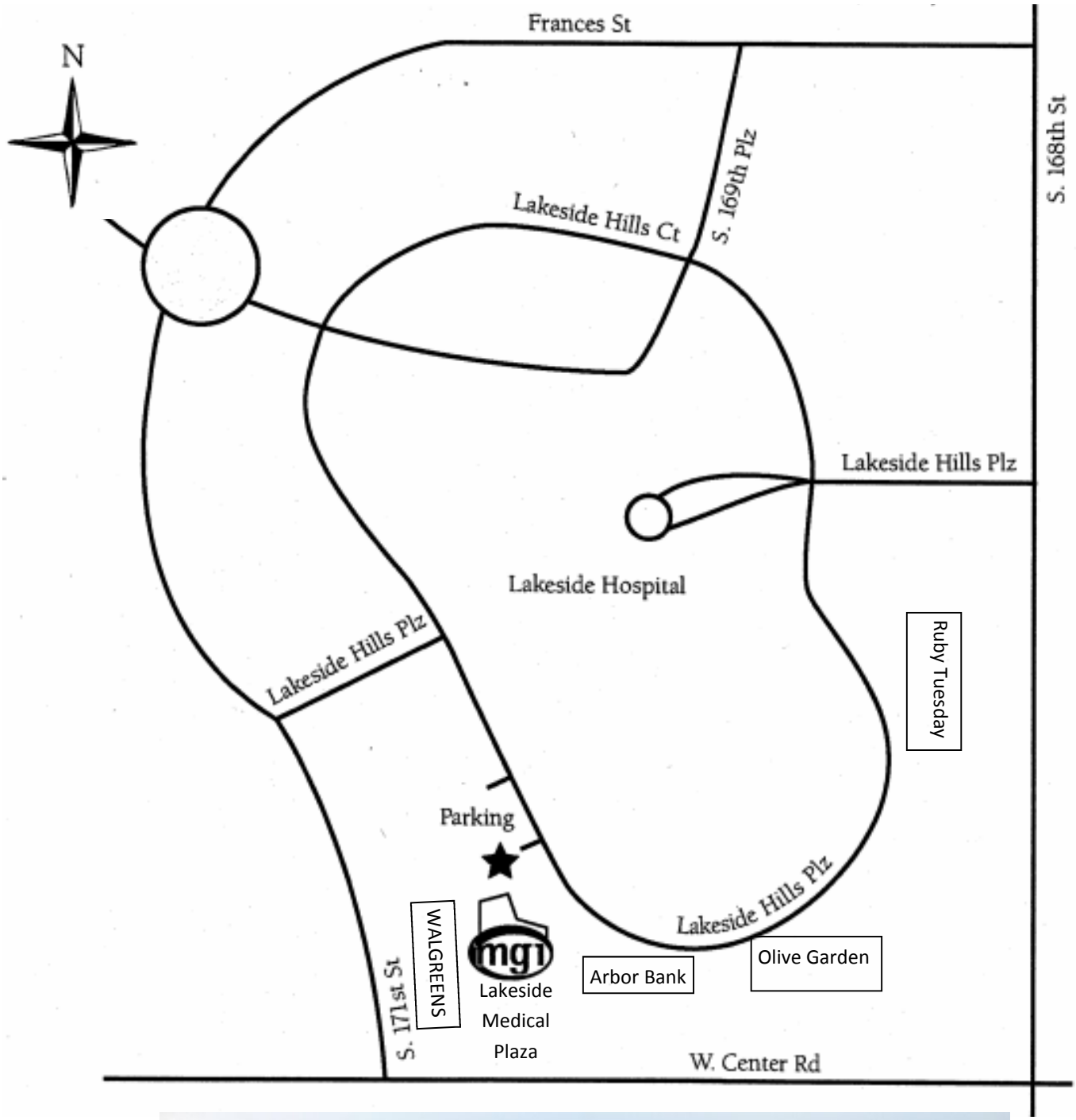
Again we would like to welcome you to Midwest Gastrointestinal Associates, PC.

Sincerely,

Midwest Gastrointestinal Associates, PC

Midwest Gastrointestinal Associates PC

Lakeside Medical Plaza Building
17001 Lakeside Hills Plaza, Suite 200
Omaha, NE 68130
402-885-8700



Midwest Gastrointestinal Associates, PC
History Form
Please complete this form in full prior to your visit

NAME: _____ **DOB:** _____

DATE: _____ **AGE:** _____ **SEX: M / F** **Primary Care Provider:** _____

ALLERGIES TO MEDICATIONS: _____

Briefly describe why you came to our clinic today: _____

CURRENT MEDICATIONS TO INCLUDE OVER THE COUNTER OR SUPPLEMENTS:

PRESCRIPTION MEDICATION NAME, DOSE (mg/units), FREQUENCY	**PRESCRIPTION MEDICATION NAME, DOSE (mg/units), FREQUENCY**

MEDICAL HISTORY

YES	NO		YES	NO	
☐	☐	Irritable Bowel Syndrome	☐	☐	Eosinophilic Esophagitis
☐	☐	Colon Polyp	☐	☐	Anal Fissures
☐	☐	Colon Cancer	☐	☐	Anal Fistula
☐	☐	Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis	☐	☐	Hemorrhoids
☐	☐	Barrett's Esophagus	☐	☐	Other GI Diseases Not Mentioned _____
☐	☐	Ulcers	☐	☐	Heart Disease
☐	☐	Esophageal Stricture	☐	☐	Lung disease
☐	☐	Celiac Disease	☐	☐	Diabetes
☐	☐	Hiatal Hernia	☐	☐	Endometriosis
☐	☐	Gallbladder Problems/Gallstones	☐	☐	Ovarian Cysts
☐	☐	Liver Problems/Hepatitis	☐	☐	Anemia
☐	☐	Diverticulosis	☐	☐	Anxiety
☐	☐	Diverticulitis	☐	☐	Depression
☐	☐	Pancreas Problems			

Do you have or are you being treated for any other medical problem not listed above? _____

_____

Date of last pelvic exam: _____ Date of onset of menopause: _____

Last menstrual period: _____ Number of pregnancies & children: _____

HAVE YOU EVER HAD AN OPERATION:

Date	Where	Type of operation and reason	Physician

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REVIEW OF SYSTEMS

Are you currently experiencing (check all that apply):

YES	NO		YES	NO	
☐	☐	Loss of appetite	☐	☐	Bloating/gas
☐	☐	Weight loss	☐	☐	A change in your bowel habits
☐	☐	Increased fatigue	☐	☐	Constipation
☐	☐	Reflux/heartburn	☐	☐	Diarrhea
☐	☐	Sore throat/burning	☐	☐	Alternate between constipation and diarrhea
☐	☐	Difficulty swallowing pills or food	☐	☐	Feeling of bowels not emptying completely
☐	☐	Difficulty swallowing liquids	☐	☐	A sense of urgency to empty your bowels
☐	☐	Regurgitation of foods or liquids	☐	☐	Incontinence of bowel
☐	☐	Nausea	☐	☐	Rectal pain
☐	☐	Vomiting	☐	☐	Rectal bleeding
☐	☐	Vomiting blood	☐	☐	Black or tarry looking stools
☐	☐	Abdominal pain – location _____	☐	☐	Mucus or pus in stools
☐	☐	Abdominal pain associated with meals	☐	☐	Jaundice (yellow eyes/skin)
☐	☐	Abdominal pain relieved by a bowel movement	☐	☐	Other symptoms _____

Have you been seen by a Gastroenterologist before? ☐ No ☐ Yes Procedures Performed? _____

Name of MD/DO: _____ Dates: _____

Prior colorectal cancer screening: ☐ No ☐ Yes Location: _____

Results: _____

Last Colonoscopy: _____ Last Upper Endoscopy: _____

Recent X-Rays: _____ Where/When: _____

Recent Blood Work: _____ Where/When: _____

FAMILY HISTORY (check all that apply):

If answered Yes, please indicate family member (GM=Grandmother, GF= Grandfather, M=Mother, F=Father, B=Brother, S=Sister, U=Unknown, O=Other)

YES	NO		Who	YES	NO		Who
☐	☐	Colon Cancer	_____	☐	☐	Ulcer	_____
☐	☐	Colon polyps	_____	☐	☐	Bleeding/Clotting Disorder	_____
☐	☐	Pancreatic Cancer	_____	☐	☐	Hemochromatosis (excess iron)	_____
☐	☐	Pancreatitis	_____	☐	☐	Gallstones	_____
☐	☐	Crohn's Disease	_____	☐	☐	Liver Disease	_____
☐	☐	Ulcerative colitis	_____	☐	☐	Cancer: Type_____	
☐	☐	Celiac Disease	_____				

Do you follow a special diet? ☐ No ☐ Yes If yes, explain: _____

Have you traveled outside the United States in the last six months? ☐ No ☐ Yes, where: _____

Any illness associated with travel? ☐ No ☐ Yes

Have you ever experienced abuse? ☐ No ☐ Yes

Alcohol Use: ☐ Use Everyday ☐ Use Some Days ☐ Used Formerly ☐ Never Used

Caffeine Use: ☐ Use Everyday ☐ Use Some Days ☐ Used Formerly ☐ Never Used

Marijuana/Cannabis: ☐ Use Everyday ☐ Use Some Days ☐ Used Formerly ☐ Never Used

Recreational Drugs: ☐ Use Everyday ☐ Use Some Days ☐ Used Formerly ☐ Never Used

Tobacco Use: ☐ Use Everyday ☐ Use Some Days ☐ Used Formerly ☐ Never Used

MIDWEST GASTROINTESTINAL ASSOCIATES, P.C.
FINANCIAL POLICY

We would like to take the opportunity to welcome you to our facility and to let you know that we are committed to providing you the best possible care. Thanks in advance for reading this information as it's critical that you understand our Financial Policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

We are here to assist you in providing information to your Health Insurance Company so that payment may be made according to the coverage you have purchased. Please keep in mind that not all services are a covered benefit in all Plans and that your insurance coverage is an agreement between you and your Health Insurance Company. Payment for services at Midwest Gastrointestinal Associates, P.C., is ultimately the patient's responsibility.

If you are scheduled for a screening colonoscopy: The Facility submits procedural documentation and charges according to Centers for Medicare and Medicaid Services and American Medical Association guidelines and is not responsible for determining how your benefits will be paid by your insurance plan. Please keep in mind that all charges may not be covered under your screening and health preventive benefits. If you have questions please call us at (402) 504-3846 for a more detailed explanation.

Providing you have insurance, we will file your primary and secondary insurance for you as a courtesy, provided we have your assignment of benefits as well as a copy of your insurance card(s) identifying your primary and secondary coverage if applicable.

If your Insurance Plan requires an authorization for care or treatment, it is the patient's responsibility to obtain one prior to your visit. Contact your Insurance Carrier if you are not sure. If a referral is not obtained, your insurance company may deny payment coverage and could result in patient responsibility.

Patient deductibles, coinsurance and co-payment amounts are established by your Health Plan and are your responsibility. You will be contacted prior to your appointment to review your insurance benefits and discuss payment arrangements for your deductibles and coinsurance.

Prompt payment of your account is expected; however, we realize that situations may arise whereby you may have difficulty meeting your obligation. If such problems do arise, we encourage you to contact us for assistance in the management of your account. We do use outside agencies as a means of collection should your account become delinquent.

Patients who fail to provide insurance information are directly responsible for payment of their account.

If you don't have insurance, acceptable financial arrangements will need to be determined prior to the date of service. An account representative will be happy to assist you and can be reached at (402) 397-7057. Please note a deposit will be required at the time of visit.

You will be billed a professional fee for the services provided by the physician's of Midwest Gastrointestinal Associates, P.C. You may also receive a bill for facility fees in the event you have a procedure done outside the offices of Midwest Gastrointestinal Associates, P.C. In addition, if lab work is necessary you may receive a separate billing for those services.

For your convenience, checks, cash, Visa, MasterCard, Discover, American Express and debit cards are accepted.

AUTHORIZATION

I have read and agree to the terms and conditions listed above and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to Midwest Gastrointestinal Associates, P.C. I understand I am financially responsible to Midwest Gastrointestinal Associates, P.C. for charges not covered or denied by my insurance company. A photocopy of this agreement shall be valid as the original. This authorization is to remain in effect until revoked in writing by me or my legal representation.

_____ _____

Signature Date