



## Welcome to Midwest Gastrointestinal Associates, PC

Dear Patient:

An appointment has been scheduled for you on \_\_\_\_\_

with Doctor \_\_\_\_\_ at

8901 Indian Hills Drive, Suite 200

Omaha, NE 68114

Phone (402) 397-7057

Fax (402) 397-6656

**Our building has white pillars with black windows and is located on the south side of Indian Hills Drive (map on reverse).**

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.

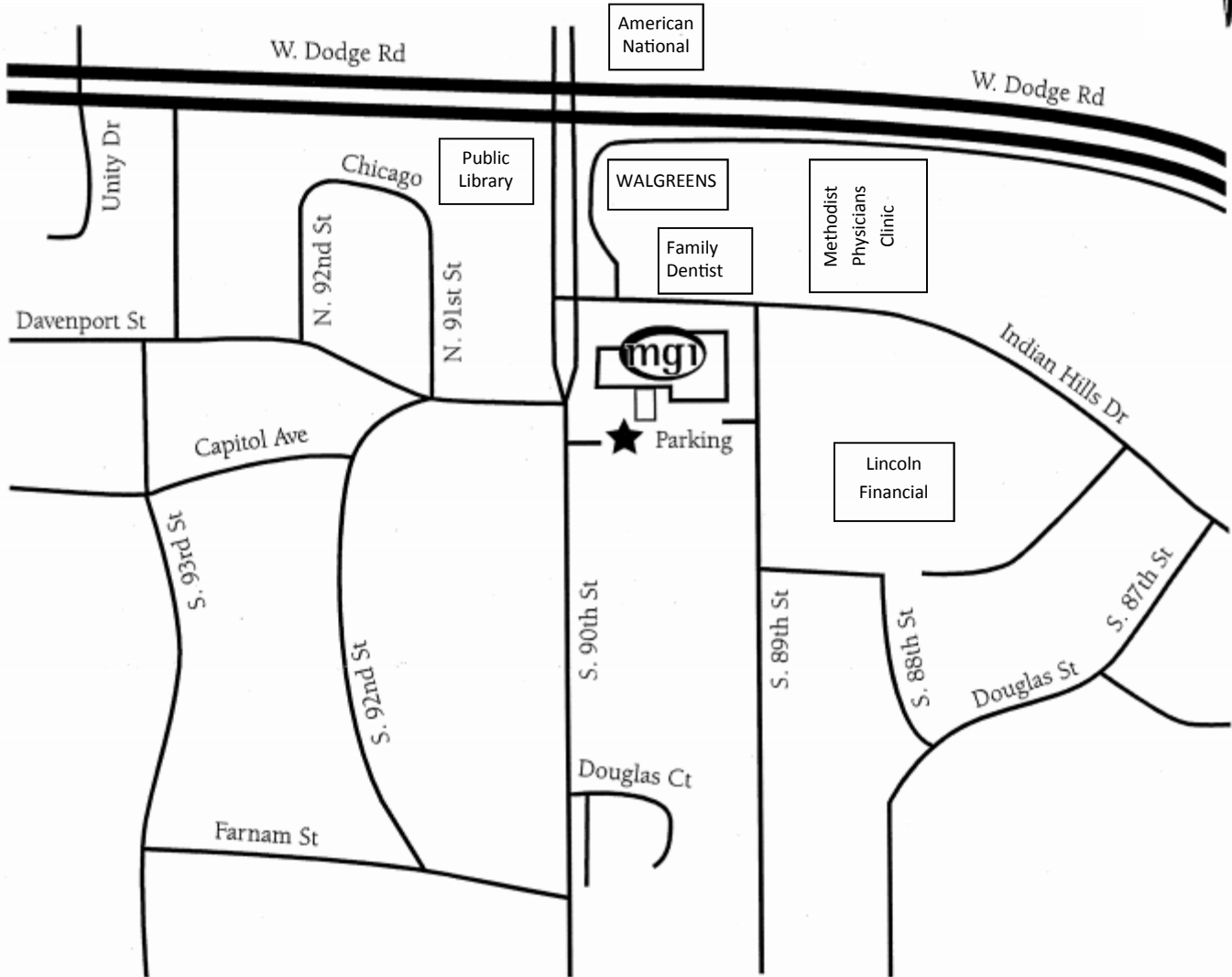
Sincerely,

Midwest Gastrointestinal Associates, PC



# Midwest Gastrointestinal Associates PC

8901 Indian Hills Drive, Suite 200  
Omaha, NE 68114  
402-397-7057



North Side of Building



South Side of Building

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 AND/OR SUPPLEMENTS:**

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

**MEDICAL HISTORY**

YES NO

- ☐ ☐ Irritable Bowel Syndrome  
☐ ☐ Colon Polyp  
☐ ☐ Colon Cancer  
☐ ☐ Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis  
☐ ☐ Barrett's Esophagus  
☐ ☐ Ulcers  
☐ ☐ Esophageal Stricture  
☐ ☐ Celiac Disease  
☐ ☐ Hiatal Hernia  
☐ ☐ Gallbladder Problems/Gallstones  
☐ ☐ Liver Problems/Hepatitis  
☐ ☐ Diverticulosis  
☐ ☐ Diverticulitis  
☐ ☐ Pancreas Problems

YES NO

- ☐ ☐ Eosinophilic Esophagitis  
☐ ☐ Anal Fissures  
☐ ☐ Anal Fistula  
☐ ☐ Hemorrhoids  
☐ ☐ Other GI Diseases Not Mentioned \_\_\_\_\_  
☐ ☐ Heart Disease  
☐ ☐ Lung disease  
☐ ☐ Diabetes  
☐ ☐ Endometriosis  
☐ ☐ Ovarian Cysts  
☐ ☐ Anemia  
☐ ☐ Anxiety  
☐ ☐ Depression

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? IF YES, PLEASE LIST BELOW:**

Date	Where	Type of operation and reason	Physician

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

**REVIEW OF SYSTEMS**

**Are you currently experiencing (check all that apply):**

<table border="0" style="width: 100%;"><tr><td style="width: 10%;">YES</td><td style="width: 10%;">NO</td><td></td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Loss of appetite</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Weight loss</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Increased fatigue</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Reflux/heartburn</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sore throat/burning</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Difficulty swallowing pills or food</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Difficulty swallowing liquids</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Regurgitation of foods or liquids</td></tr><tr><td><input 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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(s) (GM=Grandmother, GF=Grandfather, M=Mother, F=Father, B=Brother, S=Sister, U=Unknown, O=Other)*

	YES	NO	Who		YES	NO	Who
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps	_____	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Clotting Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Hemochromatosis (excess iron)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	_____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: Type _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	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

Vape/E-Cigarette 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.

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