

GULF COAST GASTROENTEROLOGY CONSULTANTS

Diplomates American Board of Gastroenterology and Internal Medicine

Joseph M. Daly, M.D.
Alan R. Klibanoff, M.D.
Richard G. LaCamera, M.D.

Michael W. Peebles, M.D.
Eric A. Steckler, M.D.
Laurence H. Zeitlin, M.D.

**PLEASE COMPLETE ALL PAGES
AND BRING THE FORMS WITH
YOU TO YOUR APPOINTMENT
PLEASE DO NOT MAIL**

VERY IMPORTANT PLEASE READ

IF THE PURPOSE OF YOUR OFFICE VISIT IS TO BE SEEN PRIOR TO A "SCREENING" PROCEDURE, PLEASE NOTE, THAT MEDICARE, SOME HMO'S, PPO'S AND PRIVATE INSURANCES, MAY NOT COVER THIS VISIT.

MEDICARE WILL PAY FOR "SCREENING" COLONOSCOPY, PROVIDED YOU HAVE NOT HAD ONE WITHIN 10 YEARS OR A SCREENING FLEXIBLE SIGMOIDOSCOPY WITHIN FOUR YEARS. HOWEVER, MANY HMO'S, PPO'S, AND PRIVATE INSURANCES MAY NOT PAY FOR A STRICTLY "SCREENING" COLONOSCOPY. IF YOUR INSURANCE COMPANY DOES NOT PROVIDE US WITH PAYMENT FOR THESE SERVICES, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

PLEASE NOTE THAT IF YOU HAVE SYMPTOMS THAT MIGHT BE FROM COLON PROBLEMS, PREVIOUS HISTORY OF COLON POLYPS, COLON CANCER, CROHNS DISEASE, ULCERATIVE COLITIS OR A STRONG FAMILY HISTORY OF COLON CANCER, MOST INSURANCE COMPANIES WILL PAY FOR COLONOSCOPIES AT APPROPRIATE INTERVALS.

IT IS SUGGESTED THAT IF YOU HAVE ANY QUESTIONS REGARDING SERVICES NOT COVERED BY YOUR INSURANCE PLAN, THAT YOU CALL YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT.

EVEN THOUGH SOME INSURANCE COMPANIES MAY NOT PAY FOR SUCH SERVICES, IT IS STILL HIGHLY RECOMMENDED THAT SUCH PROCEDURES BE DONE.

PLEASE SIGN THAT YOU HAVE READ AND UNDERSTAND THE ABOVE.

SIGNATURE

DATE

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Financial Agreement

You are responsible, as the insured and the patient, for being sure that we have your correct insurance information on file. We will ask to see your insurance card(s) at each visit. If you do not inform us of changes, or provide us with incorrect information you will be responsible for the charges incurred for office visits and any procedures that may be scheduled on your behalf.

Payments are due at the time of service, unless payment arrangements have been made prior to your appointment. We accept cash, checks, money orders, credit cards (Mastercard, Visa, and Discover). Any returned check will have an additional \$25.00 charge to the original amount of the check. The full amount is due within 10 days of the returned check.

MEDICARE: We do accept assignment on all COVERED charges by Medicare, and will file charges to them. We will file ONE subsequent insurance policy for office visits, procedures or hospitalizations. If you do not have a secondary insurance, you will be responsible for the 20% Medicare does not pay for, at the time of your office visit.

HMO's AND PPO'S: If we are a participating provider with your insurance company, we are responsible to file your claim. You, as the insured, are responsible for any co-payment, deductible, co-insurance, or payment for any non-covered service. If you have a co-payment for office visits, you will be responsible to pay that amount at the time of your office visit. If your insurance plan requires a REFERRAL OR AUTHORIZATION, it is YOUR responsibility to make sure that it is in our office PRIOR to your office visit. We suggest you contact your primary care physician at least 2 weeks before your appointment. If for some reason you do not have a REFERRAL OR AUTHORIZATION at the time of your appointment, we will either need to reschedule your appointment or you may pay for the visit in full, prior to leaving our office. However, without an authorization for the office, we will be unable to schedule any subsequent procedures you may need to have done.

PRIVATE AND INDEMNITY PLANS: We DO NOT accept assignment on your claims. You will be responsible to pay for your office visit in full at the time of service. We will file your claim to your insurance company, as a courtesy to you. It is up to you to be sure that your insurance company reimburses you for your payment. If you are scheduled for a procedure we will file your claim and you will be billed later for any balance remaining after your insurance company makes their payment. **IF YOUR INSURANCE COMPANY DOES NOT REIMBURSE YOU THE FULL AMOUNT OR PAY FOR ANY PROCEDURE IN FULL, DUE TO WHAT THEY CONSIDER "REASONABLE AND CUSTOMARY", THAT IS BETWEEN YOU AND YOUR INSURANCE COMPANY.**

In order to accommodate those patients in need of an appointment and respect for those who honor their existing ones, we ask that you provide us with at least 48 hours notice if you need to cancel or reschedule. Failure to do so may result in a cancellation fee. Thank you.

PATIENT SIGNATURE

DATE

If you have any questions regarding this agreement please do not hesitate to ask. Thank you.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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PATIENT INFORMATION

PATIENT'S NAME _____
LAST FIRST MI

PATIENT'S ADDRESS _____
CITY STATE ZIP

NORTHERN ADDRESS _____

PATIENT'S HOME PHONE # _____ CELL PHONE # _____ M F

SOCIAL SECURITY # _____ DATE OF BIRTH _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

EMPLOYER _____ WORK PHONE _____

PRIMARY CARE PHYSICIAN _____

EMERGENCY CONTACT _____ PHONE NUMBER _____ RELATIONSHIP _____

PRIMARY INSURANCE _____

POLICY # _____ GROUP # _____

POLICYHOLDER NAME _____ POLICYHOLDER DOB _____

POLICYHOLDER SS # _____ POLICYHOLDER EMPLOYER _____

INSURANCE ADDRESS _____
CITY STATE ZIP

SECONDARY INSURANCE _____

POLICY # _____ GROUP # _____

I authorize the release of any medical information necessary to process this claim. I also request that payment of Government Benefits be paid to Gulfcoast Gastroenterology Consultants. The PHI (Personal Health Information) contained is **HIGHLY CONFIDENTIAL**. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.

Also, I request that payment of authorized Medical or Medigap (if Medicare) benefits be made on my behalf to Gulfcoast Gastroenterology Associates for any services furnished me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand and agree, regardless of my insurance, I am ultimately and fully responsible for my account for any professional services rendered. I also agree to pay all collection, attorney and court fees that may be incurred for the collection of delinquent accounts.

SIGNATURE _____ DATE _____

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Please Print

DATE _____

NAME _____ PHONE _____ AGE _____

ADDRESS _____

Personal Physician _____ Address _____

Referring Physician _____ Address _____

PLEASE LIST YOUR CURRENT SYMPTOMS AND MEDICAL PROBLEMS:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

HAVE YOU EVER HAD:

REG. MEASLES	NO	YES	GER. MEASLES	NO	YES	MUMPS	NO	YES
WHOOPING COUGH	NO	YES	DIPHTHERIA	NO	YES	CHICKEN POX	NO	YES
SMALL POX	NO	YES	SYPHILLIS	NO	YES	GONORRHEA	NO	YES
TYPHOID FEVER	NO	YES	INFLUENZA	NO	YES	PNEUMONIA	NO	YES
TUBERCULOSIS	NO	YES	SCARLET FEVER	NO	YES	RHEUMATIC FEVER	NO	YES
STREP THROAT	NO	YES	POLIO	NO	YES	MENINGITIS	NO	YES

PLEASE LIST ALL OF YOUR HOSPITALIZATIONS IN CHRONOLOGICAL ORDER:

DATE	HOSPITAL	PROBLEM	DATE	HOSPITAL	PROBLEM
1. _____	_____	_____	4. _____	_____	_____
2. _____	_____	_____	5. _____	_____	_____
3. _____	_____	_____	6. _____	_____	_____

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITIONS OR ILLNESSES:

- | | |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |

ANY INJURIES:

MEDICATIONS: LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

ALLERGIES:

PENICILLIN	NO	YES	OTHER DRUGS _____
SULFA DRUGS	NO	YES	_____
BARBITURATES	NO	YES	_____
EGGS	NO	YES	_____

PERSONAL HISTORY:

PLACE OF BIRTH _____ CIGARETTES, PACKS PER/DAY _____ CIGARS PIPE

STATES IN WHICH YOU HAVE LIVED _____ ALCOHOL CONSUMPTION _____

COUNTRIES WHERE YOU LIVED OR VISITED _____ TYPE _____ QUANT. PER WEEK _____

CURRENT OCCUPATION _____ COFFEE, CUPS PER DAY _____ TEA, CUPS PER DAY _____

PREVIOUS OCCUPATION _____ REGULAR EXERCISE YES NO TYPE _____

PLEASE TURN OVER AND COMPLETE BACK PAGE

NAME _____ DATE _____

FAMILY HISTORY	AGE	IF LIVING, HEALTH	AGE AT DEATH	IF DECEASED, CAUSE	RECORD THE APPROXIMATE DATE YOU LAST HAD ANY OF THE FOLLOWING:	DATE HAD
FATHER					COMPLETE MEDICAL EXAM	
MOTHER					WOMEN – PAP SMEAR	
<input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER	1.				CHEST X-RAY	
<input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER	2.				TEST STOOL FOR BLOOD	
<input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER	3.				PROCTO	
<input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER	4.				EKG	
<input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER	5.					
HUSBAND OR WIFE						
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	1.					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	2.					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	3.					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	4.					

SYSTEMS REVIEW: Have you had any of the following problems within the past 3 months?

H. FREQUENT HEADACHES..... NO YES MIGRAINE HEADACHES..... NO YES	VOMITING BLOOD..... NO YES VOMITING NO YES CHANGE IN BOWEL HABITS..... NO YES CHANGE IN STOOL APPEAR..... NO YES CONSTIPATION NO YES DIARRHEA NO YES INTEST. PARASITES (worms) NO YES DIFFICULTY SWALLOWING NO YES FREQUENT HEART BURN..... NO YES HIATUS (HIATAL) HERNIA NO YES GALLSTONES NO YES HEPATITIS NO YES JAUNDICE (Yel. Jaundice) NO YES CIRRHOISIS OF LIVER..... NO YES	MS JOINT PAINS..... NO YES TENDER, SWOLLEN, RED OR HOT JOINTS NO YES BACK PAIN..... NO YES FREQUENT LEG CRAMPS..... NO YES
E. DOUBLE VISION..... NO YES BLURRED VISION..... NO YES SPOTS BEFORE EYES NO YES BLINDNESS..... NO YES EYE PAIN NO YES GLAUCOMA NO YES NEED FOR GLASSES..... NO YES		HEM ANEMIA NO YES TREATMENT.....DATE..... BLOOD TRANSFUSION..... NO YES WHENWHY# UNITS..... EXCESSIVE BLEEDING NO YES RECURRENT NOSE BLEEDS..... NO YES EASY BRUIISABILITY NO YES
E. EAR INFECTION NO YES RINGING IN EARS NO YES		
N. NOSE BLEEDS..... NO YES DISCHARGE..... NO YES LOSS OF SMELL..... NO YES FREQUENT COLDS..... NO YES POST NASAL DRIP NO YES	G.U. KIDNEY/BLADDER INFEC..... NO YES PAIN OR BURN. URINATION NO YES PUS IN URINE..... NO YES BLOOD IN URINE..... NO YES URINARY FREQUENCY NO YES URINARY URGENCY NO YES URINATING AFTER BEDTIME NO YES URINARY DRIBBILING NO YES KIDNEY/BLADDER STONES..... NO YES	ONC. LOSS OF APPETITE NO YES UNEXPLAINED WT. LOSS NO YES ANY LUMP OR MASS..... NO YES REMOVED.....WHEN..... UNUSUAL MOLE OR WART..... NO YES ENLARGED LYMPH NODES..... NO YES
T. FREQUENT SORE THROAT NO YES CHRONIC HOARSENESS NO YES STREP THROAT NO YES		
PULM. CHRONIC COUGH..... NO YES COUGHING BLOOD..... NO YES SPUTUM PRODUCTION..... NO YES SHORTNESS OF BREATH NO YES ASTHMA NO YES	ENDO. RECENT WT. GAIN..... NO YES EXCESSIVE SWEATING NO YES DIABETES (sugar in urine) NO YES HIGH CHOLESTEROL NO YES	MALE ONLY PROSTATE TROUBLE..... NO YES DIF. INITIATING STREAM NO YES INTERRUPTED STREAM NO YES IMPOTENCE..... NO YES
CV. CHEST PAIN NO YES HEART ATTACK..... NO YES PALPITATIONS NO YES CALF PAIN NO YES HEART MURMUR NO YES HIGH BLOOD PRESSURE..... NO YES LOW BLOOD PRESSURE NO YES FAINTING SPELLS..... NO YES	N.P. STROKE NO YES PARALYSIS OR WEAKNESS NO YES LOSS OF SENSATION..... NO YES SPEECH ABNORMALITY NO YES CONVULSION NO YES LOSS OF BALANCE..... NO YES DEPRESSION NO YES CONFUSION NO YES CRYING SPELLS NO YES NERVOUS BREAKDOWN..... NO YES	FEMALE ONLY DATE OF LAST PERIOD DURATION OF PERIODDAYS LENGTH OF CYCLEDAYS NO. OF PREGNANCIES..... EX. FLOW DURING PERIODS NO YES BLEED. BETWEEN PERIODS NO YES
GI. PEPTIC ULCER DISEASE NO YES RECUR. ABDOMINAL PAIN..... NO YES BLACK OR BLOODY STOOLS NO YES		SIGNATURE _____

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MEDICARE ONLY

(A) Notifier(s):

(B) Patient Name:

(C) Medicare Identification Number:

Advanced Beneficiary Notice of Noncoverage (ABN)

NOTE: if Medicare doesn't pay for procedure below you may have to pay.

Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the procedure below.

Procedure	Reason the Medicare may not pay	Estimated Cost:
Colonoscopy	Medicare pays for a screening colonoscopy one time every 10 years. If patient has a family history of colon cancer or any colon disease, Medicare allows colonoscopy more frequently.	

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the colonoscopy listed above.

Note: if you choose option one or two we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

Option 1. I want the colonoscopy listed above. You may ask to be paid now, but I also want Medicare billed for the official decision on payment, which is said to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. That Medicare does pay; you will refund any payments I made to you, less co-pays or deductibles.

Option 2. I want the colonoscopy listed above, but do not bill Medicare. You may be asked to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

Option 3. I don't want the colonoscopy listed above. I understand with this choice I'm not responsible for payment and **I cannot appeal to see if Medicare would pay.**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048)

Signing below means that you have received and understand this notice. You will also receive a copy.

Signature: _____ Date: _____

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Any Other Insurer than Medicare

Advanced Beneficiary Notice of Noncoverage (ABN)

Note: The purpose of this form is to help you make an informed decision about whether or not you elect to receive the following services. Your insurance company only pays for **COVERED** services, as stated by your insurance company. We are informing you that your insurance company **MAY NOT** pay for: **SCREENING COLONOSCOPY**

Please read carefully:

We suggest you contact your insurance company with any questions you may have regarding your benefits for this procedure. If you contact them, you may need the following information: procedure code 45378 and diagnosis code V76.51. These codes are exactly how we bill them to your insurance, provided it is strictly as “screening” procedure. However, when the Doctor performs the procedure, the diagnosis will be billed according to the findings (i.e., Polyps) regardless of the original reason for the procedure. Many insurance companies are now offering screening colonoscopy at 100%*HOWEVER*** if anything is found on your colonoscopy (polyps, etc.), your insurance company most likely WILL NOT pay at 100% and will apply this to your regular medical benefits. This would include deductible, coinsurance, out of pocket, and copays. It would be FRAUDULENT to bill the procedure as screening if polyp’s or any other pathology are found.**

The fact that your insurance company may not cover this procedure does not mean you should not have this done. There is a valid reason your Doctor recommended this procedure.

(Patient Signature)

(Date)

(Patient’s printed name)

(Account #)