GASTROINTESTINAL HEALTHCARE
Improving Your Health From The Inside Out.
2011 Falls Valley Drive, Suite 106, Raleigh, NC 27615
Phone: 919-870-1311 Fax: 919-881-0822
www.giraleigh.com

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____
MRN:_____ Date Of Birth:_____
Age:_____ Notes:_____

Email
Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Effective January 1, 2010 all freestanding surgical facility providers are required to report to the Division of Public Health any self-reported race and ethnicity data provided by the patient. If you choose to self-report this information, please bubble in the appropriate race and ethnicity. If you choose not to report this information, please select "Patient declines to provide information" in both sections.

Race
Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Unknown ☐ Patient declines to specify

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify Other:_____

Contact Preference

☐ Home phone ☐ Business phone ☐ Cell phone ☐ Mail ☐ Email
☐ Patient Portal ☐ Patient declines to specify

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Latex	☐ Adhesive Tape	☐ Soy	☐ NC Nuts	☐ NC Eggs
☐ NC Mangoes	☐ Nickel	☐ Propofol	☐ Fentanyl	☐ Midazolam
☐ Lidocaine	☐ Iodine	☐ Morphine	☐ Codeine	☐ Penicillins
☐ Sulfa	☐ Aspirin	Other:_____	Other:_____	Other:_____

Current Medications and dosages, including over-the-counter & supplements

☐ None

Name:_____ Name:_____
Name:_____ Name:_____
Name:_____ Name:_____
Name:_____ Name:_____
Name:_____ Name:_____

Immunizations

- ◯ None

- ◯ Hep A, adult When:_____
- ◯ Hep B, adult When:_____
- ◯ Flu vaccine When:_____
- ◯ Pneumonia When:_____

Diagnostic Studies/Tests

- ◯ None

- ◯ CT Scan
- ◯ Ultrasound
- ◯ Colonoscopy
- ◯ Endoscopy
- ◯ Sigmoidoscopy

Past or Present Medical Conditions

- ◯ None

- ◯ Acid Reflux
- ◯ Anemia
- ◯ Asthma
- ◯ Atrial Fibrilation
- ◯ Back Pain (chronic)
- ◯ Breast cancer
- ◯ Cancer
- ◯ Chronic Lung Disease
- ◯ Cirrhosis
- ◯ Colitis
- ◯ Colon Cancer
- ◯ Colon Polyps
- ◯ Congestive Heart Failure
- ◯ Crohn's Disease
- ◯ Diabetes
- ◯ Diarrhea
- ◯ Diverticulitis
- ◯ Diverticulosis
- ◯ Depression
- ◯ Emphysema
- ◯ Fatty Liver
- ◯ Frequent Urinary Tract Infections
- ◯ Gallstones
- ◯ Gastric Ulcer
- ◯ Glaucoma
- ◯ Gout
- ◯ Heart Attack
- ◯ Heart Murmurs
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Hiatal Hernia
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ High Triglycerides
- ◯ History of Suicide Attempts
- ◯ HIV/AIDS
- ◯ Irregular Heartbeat
- ◯ Irritable Bowel Syndrome
- ◯ Kidney Disease
- ◯ Kidney Failure
- ◯ Kidney Stones
- ◯ Lactose Intolerance
- ◯ Lupus
- ◯ Migraines
- ◯ Mitral Valve Prolapse
- ◯ Myocardial Infarction
- ◯ Neurological Disorders
- ◯ Osteoarthritis
- ◯ Pancreatitis
- ◯ Parkinson's Disease
- ◯ Phlebitis
- ◯ Pneumonia
- ◯ Positive TB Skin Test
- ◯ Rheumatic Fever
- ◯ Rheumatoid Arthritis
- ◯ Seizures
- ◯ Skin Cancer
- ◯ Sleep Apnea
- ◯ Stroke
- ◯ Thyroid Disease
- ◯ TMJ
- ◯ Tuberculosis
- ◯ Uterine Cancer
- ◯ I, the patient, have traveled outside the US in the past 21 days.

Do you currently have any of the following symptoms?

- ◯ Fever
- ◯ Productive cough
- ◯ Unexpected weight loss
- ◯ Night sweats

Previous Procedures

- ◯ None

- ◯ Appendectomy
- ◯ Breast Surgery R or L
- ◯ C-Section
- ◯ Cardiac Catheter
- ◯ Colon Resection
- ◯ Defibrillator
- ◯ Gallbladder
- ◯ Heart Bypass
- ◯ Heart Stent
- ◯ Heart Valve Replacement
- ◯ Hemorrhoid
- ◯ Hernia Repair
- ◯ Hysterectomy
- ◯ Joint Replacement
- ◯ Kidney
- ◯ Liver Biopsy
- ◯ Obesity
- ◯ Pacemaker
- ◯ Prostate Surgery
- ◯ Stomach
- ◯ Thyroid
- ◯ Tonsillectomy
- ◯ Transplant
- ◯ Tubal Ligation
- ◯ Vasectomy

Other:_____ Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Civil Union

Alcohol

- ◯ None
- ◯ Rarely
- ◯ Less than two days per week
- ◯ More than two days per week
- ◯ Daily
- ◯ I quit using alcohol

Caffeine

- ◯ None
- ◯ Coffee
- ◯ Tea
- ◯ Soda

Tobacco

Smoking Status

- ◯ Current every day smoker
- ◯ Current some day smoker
- ◯ Former smoker
- ◯ Never smoker
- ◯ Smoker, current status unknown
- ◯ Light tobacco smoker
- ◯ Heavy tobacco smoker
- ◯ Unknown if ever smoked

Drug Use

- ◯ None
- ◯ Tylenol/Acetominophen
- ◯ Advil/Ibuprofen
- ◯ Aleve/Naproxen
- ◯ Aspirin

Exercise

- ◯ None
- ◯ I walk
- ◯ I jog
- ◯ I bike
- ◯ I swim
- ◯ I golf
- ◯ I do aerobics
- ◯ I lift weights

Family Medical History

- ◯ No knowledge of family history

No family history of

- ◯ Colon Cancer
- ◯ Colon Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Other
Colitis	◯	◯	◯	◯	◯	◯	◯	◯	◯
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Colon Polyps	◯	◯	◯	◯	◯	◯	◯	◯	◯
Crohn's Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯	◯	◯	◯
Esophageal Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Gallbladder Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯
Liver Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pancreatic Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Stomach Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Ulcer Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯
Ulcerative Colitis	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other: _____	◯	◯	◯	◯	◯	◯	◯	◯	◯

Review of Current Symptoms

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
recurrent infections	○	○
strong allergic reactions or rashes	○	○

Cardiovascular

None	Y	N
chest pain	○	○
shortness of breath with exercise	○	○
irregular heart beat	○	○
shortness of breath when lying flat	○	○
palpitations	○	○
swelling of the lower limbs	○	○
fainting	○	○

Constitutional

None	Y	N
extreme exhaustion	○	○
fever	○	○
loss of appetite	○	○
general discomfort or uneasiness	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
difficulty breathing through nose	○	○
nose bleeds	○	○
sore throat	○	○
jaw pain, popping	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

None	Y	N
seeing double	○	○
loss of vision	○	○
light sensitivity	○	○

Gastrointestinal

None	Y	N
abdominal bloating	○	○
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
difficulty swallowing	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
painful urination	○	○
frequent urinary infections	○	○
frequent urination	○	○
blood in urine	○	○
impotence	○	○
nighttime urination	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or swollen glands	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
history of suicide attempt	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
difficulty breathing	○	○
excessive saliva	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Name of patient's pharmacy: _____

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

This allows us to obtain current, accurate information regarding your prescription medications, which helps us to identify potentially dangerous drug interactions.

☐ Yes ☐ No

Consent to Share Data

I consent to allow GIH to share my medical and demographic information between providers related to my course of treatment, such as my primary care or referring physician.

☐ Yes ☐ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

GIH would like to provide you with medical treatment reminders at the recommendation of your physician.

☐ Yes ☐ No

Patient signature: _____ **Date:** _____

For office use only:

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

PATIENT REGISTRATION (please print)

Today's Date: ____/____/____ Birthdate:____/____/____ S.S.# _____/____/_____

Patient
Name:_____Age:_____Sex:_____
Last First Middle

Address:_____
Street Apt# City State
Zip

Home Phone: ( )_____ Business Phone: ( )_____ Cell: ( )_____

Can we leave your medical information on your voice mail? □ Yes □ No

Emergency contact: ( )_____ Name:_____ Relationship:_____

Primary Insurance Co:_____ Secondary Insurance Co:_____

Employer:_____

How did you hear about our office? _____ Referring Physician: _____

I authorize the attending physicians to administer medical care as necessary. GIH will file all insurance claims as a courtesy to you, our patient. Given that we contract with your insurance company, we **are required** to collect all co-pays, deductibles and co-insurance due associated with your procedure. If you have any questions regarding your outstanding deductible and/or procedure co-pays and/or co-insurance, please consult your insurance company prior to procedure. I hereby authorize payment directly to GastroIntestinal Healthcare for all medical services provided to me, for benefits otherwise payable to me. This is to include major medical insurance and payment of surgical or medical benefits. I understand that I am financially responsible to the physicians and their associates for charges not covered by assignment. I understand that should it become necessary to pursue collections through an outside agency for unpaid medical services, I will be responsible for all reasonable collection and attorney fees.

All deductibles, co-insurance and co-pays are due at the time of service. If you have no insurance, payment in full is expected at time of service. We accept cash, checks, or all credit cards.

I authorize the release of all records by GastroIntestinal Healthcare for the purpose of processing medical claims. I authorize the release of all medical information in the possession of this medical office to any consultants or medical personnel for the purpose of rendering treatment to myself, and/or to continue my care. I understand I can revoke this authorization at any time by notification in writing.

I agree that GastroIntestinal Healthcare and affiliated agencies to contact the numbers listed above, including wireless telephone numbers, which may result in charges to me. I also authorize to be contacted via text messages and/or emails to the telephone number and email address I provided above. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device as applicable. By signing this document I agree to have read the above disclosure and agree that GastroIntestinal Healthcare and affiliated agencies may contact me.

I certify that I understand and agree to the above releases and assignment of benefits.

Patient signature:_____ Date:_____

Guardian signature (if applicable):_____ Date:_____

GastroIntestinal Healthcare (GIH) Financial Policy

Insurance: Most insurance plans cover the cost of the procedure, less any applicable co-pays, co-insurance, and deductibles. It is your responsibility to: check with your plan in advance to ensure that we participate with your insurance plan, review your benefit coverage; and ensure all pre-approval requirements are met to avoid denials or out-of-network benefits. Your policy is a contract between you and your insurance company. We are not a part of that contract and cannot guarantee payment by your insurance carrier. If your insurance plan does not pay for all services or denies coverage, you will be fully responsible for all contracted fees due. If your insurance company denies payment of your claim, contact your insurance company directly. We will allow your insurance company 45 days to pay your insurance claim. If they have not paid by the 46th day, you will be held entirely responsible for any balance due, and you will be billed accordingly. Dissatisfaction with your insurance company does not constitute reason to withhold payment of your account with GIH. We do accept assignment of your benefits; however, please be aware that some or all of the services provided may be a non-covered service under your plan. You will be responsible for these non-covered charges. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

All co-pays, deductibles and co-insurance are due at the time of treatment. We must receive your billing information at each visit in order to meet claims submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information necessary to process your claim, you will be held responsible. We must have a copy of your current insurance card to file for you or your family member. If you do not have your insurance card, we will ask for payment in full at the time of visit.

In summary, your financial responsibility pertains to:

- Denied and non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information
- Non-insurance and/or out of network benefit
- Self-pay patients must pay in full at time of service

Costs: Depending on our contract with your particular insurance carrier, your procedure could result in a combination of the following fees:

1. Professional Fee – this is the Doctor's charge for performing the procedure.
2. Facility Fee – this is the charge for the Endoscopy Center.
3. Pathology Fee – if a biopsy is needed, you will be billed separately for these services, which are not included in the Financial Estimate provided to you prior to your procedure.
4. Anesthesia Fee – you may be billed separately for anesthesia services by Carolina Anesthesia. This charge is not included in the Financial Estimate that we provide to you prior to your procedure.

Estimates: Any charges you were provided when you scheduled your procedure were ESTIMATES only for the Physician and Facility. We have no way of stating exactly what the charges will be prior to a procedure, and your treatment may change. Estimates do not include pathology or anesthesia fees, which are billed separately. We cannot waive amounts defined as patient responsibility as such waiver could violate State and Federal laws.

Payment Options: We accept all credit cards, cash, money orders, checks and Care Credit. If you do not have a Care Credit Account, please go to our website at www.giraleigh.com, or call our office at 919-870-1311 for directions on how to apply for this payment option, which must be completed and approved **prior** to the date of your procedure. We accept electronic payments through our website secure on-line patient payment portal at www.giraleigh.com. A service charge of $35.00 will be applied to your account for all returned checks or any stopped payment on an issued check.

Collection Accounts: Any past due balances not paid will be turned over to a collection agency after 45 days unless payment arrangements have been made with GIH.

Refunds: GIH will issue refunds once all insurance claims have been paid and your account has a credit balance. Refunds will not be issued for amounts less than $10.00. Refunds are issued bi-weekly.

Missed Appointments: We require a 24-hour notice of cancellation for all appointments. If we don't receive at least 24 hours advance notice, we may charge you a $25.00 missed appointment fee. This charge will not be billed to your insurance company.

Authorization: I agree to be responsible for any medical expenses incurred with GIH, therefore, I authorize my insurance company, attorney, or other parties to pay directly to GIH, and/or provide any information regarding payment of my bill. I have read, understood, and agreed to the financial policy stated above and I accept responsibility for any balance not covered by my insurance company.

Signature of Patient or Responsible Party:_____ **Date**: _____

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MEDICAL RECORDS & HEALTH INFORMATION RELEASE

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

****Can we leave your medical information on your voice mail? ☐ Yes ☐ No**

****Name of patient's pharmacy: _____**

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) A COPY OF OUR PATIENTS RIGHTS AND PATIENT RESPONSIBILITIES POLICIES ARE AVAILABLE AT WWW.GIRALEIGH.COM. I acknowledge that a copy of GastroIntestinal Healthcare's Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I further acknowledge that I have received a copy of GIH's Patient Rights and Patient Responsibility Policies.

Please be advised that without your *written authorization* we cannot discuss your case, treatment, or your pre – and post-procedure care instructions with *anyone* other than yourself. We need specific *written authorization* from you in order to be able to do so. Please indicate below with whom we may discuss your healthcare.

I hereby authorize GastroIntestinal Healthcare (GIH) to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatments rendered.

Medical records may be disclosed to the following Physicians:

_____

_____

Please list any additional parties (e.g. spouse, children, significant other, or person responsible for providing care to you) to whom information, such as post-operative instructions, may be disclosed by GIH:

_____

Name of Person(s) (Family member or Friend) and/or Organization

If you would like to authorize someone other than yourself for GIH to speak with regarding your medical bills/financial responsibility, please provide authorization for us to speak to them regarding your account.

_____

Name of Person(s) (Family member or Friend) and/or Organization

Expiration date of authorization: This authorization is effective for one year from the date signed unless revoked or terminated by the patient or patient's representative.

Right to terminate or revoke authorization: You may revoke or terminate this authorization by submitting a written revocation to GastroIntestinal Healthcare. You should contact the Privacy/Compliance Officer to terminate this authorization.

Potential for re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under Federal Privacy Regulations.

Patient Name (please print): _____ Date of Birth: _____

Patient Signature: _____ Date of Signature: _____

Signature of Patient Representative:_____ Relationship: _____

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 877-8353.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (888) 877-8353.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (888) 877-8353.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (888) 877-8353.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (888) 877-8353.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (888) 877-8353 번으로 전화해 주십시오.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (888) 877-8353.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (888) 877-8353.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (888) 877-8353.

Tagalog-Filipino: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (888) 877-8353.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (888) 877-8353.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (888) 877-8353.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(888) 877-8353.まで、お電話にてご連絡ください。

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (888) 877-8353.पर कॉल करें।

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (888) 877-8353 'ਤੇ ਕਾਲ ਕਰੋ।

GastroIntestinal Healthcare (919) 870-1311