PREMIER
GASTROENTEROLOGY

Doctor:_____
Date: _____
Account # _____

INSURANCE VERIFICATION FORM

Full Name: _____ Date of Birth: _____

SSN (Social Security Number): _____ Email Address: _____

Phone: _____ Address: _____

Marital Status (circle one): Single Married Widowed Divorced Sex (circle one): M F

Employer: _____ Phone: _____ Address: _____

Doctor Information:

Referring Physician: _____ Phone: _____ Address: _____

Family Physician: _____ Phone: _____ Address: _____

Primary Insurance:

Insurance Company: _____ Address: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship: _____ SSN: _____

Date of Birth: _____ Employer: _____ Sex (circle one) M F

Secondary Insurance:

Insurance Company: _____ Address: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Relationship: _____ SSN: _____

Date of Birth: _____ Employer: _____ Sex (circle one) M F

WE WILL BE GLAD TO HELP YOU FILE FOR YOUR INSURANCE BENEFITS; PAYMENT OF YOUR CHARGES SHOULD NOT BE DEPENDENT UPON PAYMENT OF INSURANCE BENEFITS.

I understand I will be responsible for all billable services not covered by insurance. I authorize Premier Gastroenterology Associates to release medical information necessary to claim reimbursement from insurance companies to whom a claim has been submitted. I understand Premier Gastroenterology Associates will refund me promptly and overpayment on my account. This authorization and assignment may be revoked by me at any time by written notice.

Patient/Guardian: _____ Date: _____ Relationship: _____

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GASTROENTEROLOGY

TERENCE L ANGTUACO, M.D. ANGELO G. COPPOLA, M.D. BRIAN HUGHES, M.D. R. STEVEN JONES, M.D.
DAVID MCELREATH, D.O. DHAVAL PATEL, M.D. R. PAUL SVOBODA, M.D.

General Consent for Care and Treatment Consent

TO THE PATIENT: ***You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform he evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended and (2) you consent to treatment at this office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any tests ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and/or a mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures, are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consent.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Date
Signature of Witness	Date
Signature of Witness	Date

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HIPAA RIGHT OF ACCESS FOR MY FAMILY MEMBER/FRIEND

I, _____, direct my healthcare provider and medical services providers and payers to disclose and release my health information described below to:

Name _____ Relationship: _____

Contact Information: _____

Health information to be disclosed upon the request of the person named above – (Check either A or B):

- ☐ A. **Disclose** my complete health record (including, but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify): _____

Form of disclosure (unless format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until one calendar year from the date signed below OR you may revoke this authorization in writing at any time by notifying your health care providers.

_____ _____
Name of the Individual Giving this Authorization Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access 45 CFR § 164.524

PREMIER
GASTROENTEROLOGY

Patient Consent for Financial Communications

Patient Name: _____ Date of Birth: _____

1. **Financial Agreement.** I acknowledge that Premier Gastroenterology Associates will bill my insurance company for services provided to me as a courtesy. I agree to pay for services that are not covered or covered charges not paid in full, including, but not limited to, any co-payment, co-insurance, deductible, or charges not covered by insurance; I understand that there is a $25.00 fee for returned checks.

2. **Cancellations and No-Show appointments.** If you do not cancel your appointment within 24 hours of your scheduled appointment or fail to show up for an appointment, you will be charged a fee of $35.00 (thirty-five dollars). Also, if you do not cancel your appointment within 72 hours of your scheduled procedure or fail to show up for a procedure, you will be charged a fee of $300.00 (three hundred dollars).

3. **Assignment of Benefits.** I hereby assign to Premier Gastroenterology Associates any insurance or other third-party benefits available for health services provided to me. I understand Premier Gastroenterology Associates has the right to refuse or accept the assignment of such benefits; if these benefits are not assigned to Premier Gastroenterology Associates, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **Consent to Telephone Calls for Financial Communications.** I agree that in order for Premier Gastroenterology Associates and collection agents to service my account or to collect any amounts I may owe, I expressly agree and consent to Premier Gastroenterology Associates any or collection agent may contact me by telephone at any telephone number without limitation of wireless, I have provided, or Premier Gastroenterology Associates or collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Contact methods may include using pre-recorded/artificial voice messages or an automated dialing service.

5. **Ancillary Services and Procedural Consent.** I understand that as a patient of Premier Gastroenterology Associates, I may require ancillary services as part of my treatment. These services may include but are not limited to lab tests, diagnostic imaging, pathology, anesthesia series, and endoscopy procedures. I acknowledge that I am responsible for payment for any ancillary services and procedures not covered by my insurance plan; I acknowledge that it is my responsibility to inform Premier Gastroenterology Associates of any changes in my insurance coverage.

Patient/Patient Representative Signature: _____ Date: _____

If you are not patient, please identify your relationship to the patient (circle relationship below)

Spouse Guarantor Parent Healthcare Power of Attorney Legal Guardian

Other (please specify): _____

PREMIER
GASTROENTEROLOGY

(501) 747-2828
www.pgalr.com
Correspondence and Mailing:
PO Box 26618
Little Rock, Arkansas 72221
Physical Address:
10915 N. Rodney Parham Rd
Suite A&B
Little Rock, AR 72212

Patient Responsibilities:

Providing Information: You are responsible for providing accurate and complete information about your medical history, current symptoms, medications, allergies, and other relevant information.

Following Instructions: You are responsible for following your healthcare provider's instructions regarding your care, treatment, medications, and appointments.

Respect and Cooperation: You are responsible for treating our staff and other patients with respect and cooperation and following our facility's rules and policies.

Payment: You are responsible for providing accurate insurance information, paying any copayments or deductibles at the time of service, and resolving any financial obligations in a timely manner.

Communication: You are responsible for asking questions, seeking clarification, and communicating any concerns or changes in your condition to your healthcare providers.

Safety: You are responsible for taking reasonable precautions to ensure your own safety and the safety of others while receiving medical care.

Feedback: You are encouraged to provide feedback about your experience with our practice, including suggestions for improvement.

By signing below, you acknowledge that you have read and understood the above rights and responsibilities. Please do not hesitate to ask a staff member if you have any questions or concerns.

Patient Signature: _____

Date: _____

Terrace L. Angtuaco, MD Angelo G. Coppola, MD Kenneth Coggins, MD Brian Hughes, MD Johnny Jones, MD
David McElreath, DO Dhaval Patel, MD R. Paul Svoboda, MD Scott Wofford, MD

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Patient Rights and Responsibilities

Premier Gastroenterology is committed to providing our patients with the highest quality of care. We believe that understanding your rights and responsibilities as a patient is essential to maintaining a positive and effective patient-provider relationship. Please review the following information carefully and let us know if you have any questions or concerns.

Patient Rights:

Respect and Dignity: You have the right to be treated with respect, dignity, and compassion by all members of our staff, regardless of your race, ethnicity, religion, gender, sexual orientation, age, or disability.

Quality Care: You have the right to receive high-quality medical care that meets or exceeds professional standards.

Informed Consent: You have the right to be fully informed about your medical condition, treatment options, risks, benefits, and alternatives and to participate in decisions regarding your care.

Privacy and Confidentiality: Your medical records and personal information will be kept confidential in accordance with state and federal laws. You have the right to review and request copies of your medical records.

Access to Information: You have the right to access information about our services, fees, and billing practices, as well as information about your rights and responsibilities as a patient.

Timely Care: You have the right to receive timely medical care and to be informed of any delays or changes in your scheduled appointments.

Communication: You have the right to effective communication with your healthcare providers, including the right to have an interpreter if you have difficulty understanding or speaking English.

Grievances: You have the right to express grievances or complaints about your care without fear of reprisal and to have them addressed in a timely and respectful manner.

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GASTROENTEROLOGY

10915 N. Rodney Parham, Suite I
Little Rock, AR 7221
(501) 747-282

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:_____

Race

Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Patient declines to specify Other:_____

Pharmacy

Name Address Phone

Allergies

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

☐ Adhesive Tape ☐ Codeine Sulfate ☐ Erythromycin ☐ Penicillins ☐ Shellfish

☐ Iv Dye, Iodine Containing ☐ Latex gloves ☐ Allergy to eggs ☐ Influenza vaccine allergy

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Hep A When:_____ ☐ Hep B When:_____ ☐ Pneumovax When:_____ ☐ TB skin test When:_____ ☐ Influenza Vaccine Received Elsewhere When:_____

Diagnostic Studies/Tests

☐ None

☐ Colonoscopy When:_____ ☐ EGD When:_____ ☐ CT Abdomen/Pelvis When:_____ ☐ MRI Abdomen/Pelvis When:_____ ☐ Abdominal Ultrasound When:_____

☐ Orbera Balloon Placement When:_____

Previous Procedures

☐ None

☐ Gallbladder removed ☐ Appendectomy ☐ Colon resection ☐ Small Bowel Resection ☐ Exploratory Laparoscopy

☐ Gastric Bypass ☐ Gastric Lap Band ☐ Hemorrhoidectomy ☐ Hemorrhoid banding ☐ Abdominoplasty

☐ Hysterectomy - Abdominal ☐ Bilateral Tubal Ligation (BTL) ☐ Mastectomy R Breast ☐ Pacemaker Insertion ☐ Defibrillator Placement

☐ Coronary Artery Bypass Graft (CABG) ☐ Abdominal aortic aneurysm (AAA) repair ☐ Heart valve replacement ☐ Cardiac Cath - with stent placement ☐ Joint Replacement

☐ Back Surgery ☐ Fibromyalgia ☐ Colectomy - total Other:_____ Other:_____

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

☐ Colon polyp history When:_____ ☐ Colon cancer When:_____ ☐ Irritable Bowel Syndrome When:_____

- ☐ Diverticulitis When:_____ When:_____
- ☐ Crohn's Disease When:_____
- ☐ Ulcerative Colitis When:_____
- ☐ Barrett's Esophagus When:_____
- ☐ Ulcer Disease When:_____
- ☐ Hepatitis B When:_____
- ☐ Hepatitis C When:_____
- ☐ Fatty Liver When:_____
- ☐ Cirrhosis When:_____
- ☐ Celiac Disease When:_____
- ☐ Bowel Obstruction When:_____
- ☐ Pancreatitis When:_____
- ☐ Anemia When:_____
- Other:_____

Cardiology

- ☐ Coronary Artery Disease When:_____
- ☐ Congestive Heart Failure When:_____
- ☐ Heart Attack When:_____
- ☐ Atrial Fibrillation When:_____
- ☐ Vascular Disease When:_____
- ☐ High Cholesterol When:_____
- ☐ Stroke When:_____
- ☐ Transient Ischemic Attack When:_____
- ☐ Valvular heart disease When:_____
- ☐ Pacemaker When:_____
- ☐ Coronary Artery Stents When:_____
- ☐ Essential Hypertension When:_____
- Other:_____ Other:_____

Pulmonology

- ☐ C.O.P.D. When:_____
- ☐ Asthma When:_____
- ☐ Sleep apnea When:_____
- ☐ Blood Clots (leg) When:_____
- ☐ Blood Clots (lung) When:_____
- ☐ Wheezing When:_____
- Other:_____ Other:_____

Other

- ☐ Anxiety disorder When:_____
- ☐ Arthritis When:_____
- ☐ Bipolar disorder When:_____
- ☐ Body piercings When:_____
- ☐ Breast cancer When:_____
- ☐ Current pregnancy When:_____
- ☐ Depression When:_____
- ☐ Diabetes Mellitus, Insulin Dependent (Type 1) When:_____
- ☐ Diabetes Mellitus, Non-Insulin Dependent (Type 2) When:_____
- ☐ Fibrositis / Fibromyalgia When:_____
- ☐ Gout When:_____
- ☐ HIV exposure When:_____
- ☐ HIV infection When:_____
- ☐ Hypothyroidism When:_____
- ☐ Kidney disease When:_____
- ☐ Kidney stones When:_____
- ☐ Lung cancer When:_____
- ☐ Ovarian Cancer When:_____
- ☐ Prostate Cancer When:_____
- ☐ Skin Cancer When:_____
- ☐ Seizures When:_____
- ☐ Tattoos When:_____
- ☐ Dementia When:_____
- ☐ Alzheimer's disease When:_____
- ☐ End-stage renal disease When:_____
- ☐ History of falling When:_____
- ☐ Dependence on supplemental oxygen When:_____
- ☐ Dependence on wheelchair When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Civil Union ☐ Unknown ☐ Other

Alcohol

☐ None
☐ Occasionally ☐ Daily

Caffeine

☐ None
☐ Occasionally ☐ Daily

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

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				

Drug Use

☐ None

Type	Quantity	Number	Frequency
☐ IV or intranasal drugs			Times / month
☐ Recreational			Times / month

Exercise

☐ None
☐ Regular exercise ☐ Occasional exercise

Family Medical History

☐ No knowledge of family history

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Health Status						
Alive	○	○	○	○	○	○
Deceased/At Age	○ ___	○ ___	○ ___	○ ___	○ ___	○ ___
Cause of Death						
Diagnoses						
Celiac disease	○	○	○	○	○	○

Colon cancer	O	O	O	O	O	O
Colon polyps	O	O	O	O	O	O
Crohn's disease	O	O	O	O	O	O
Gallbladder disease	O	O	O	O	O	O
Liver disease	O	O	O	O	O	O
Ulcerative colitis	O	O	O	O	O	O

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Endocrine

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

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
photophobia	○	○

Gastrointestinal

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

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

None	Y	N
allergies	○	○
hives	○	○
itching	○	○
rashes	○	○

Musculoskeletal

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

Neurological

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

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Consent to Import Medication History

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

◯ Yes ◯ No

Reminder Preference

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

◯ Yes ◯ No

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present

Signature

Signature Date