# ACADIANA GASTROENTEROLOGY ASSOCIATES, LLC.

*The Center for Digestive Care*

439 HEYMANN BOULEVARD, LAFAYETTE, LOUISIANA 70503 - PH: 337-269-0963 FAX: 337-269-0553
www.acadianagastro.com

Welcome to Acadiana Gastroenterology Associates. Please complete the enclosed forms and bring with you when keeping your appointment on:

_____

Please note the following prior to your scheduled appointment.

**CANCELLATION POLICY**: Acadiana Gastroenterology Associates, LLC requires a 48 hour cancellation notice before your scheduled appointment.

**OUR LOCATION**: Our physical address is 439 Heymann Blvd., Lafayette, Louisiana, 70503. We are located in the 'Grant-Molett Medical Arts Plaza' at the intersection of Heymann Boulevard and South College Road.

**BEFORE YOUR VISIT**: For payment and coverage purposes, it is very important that you contact your insurance prior to the initial office visit in order to assure that the attending Physician is covered on your plan or participating in your insurance's network. By doing so, your insurance will inform you if you must first see your Primary Care Physician, if a referral is required, or if there are any co-pays and/or deductibles pertaining to your visit. *Please **bring any blood test results, scans, or x-rays performed recently with any other physician(s)*** if available.

**PAYMENT METHODS**: The initial office visit may vary from $71.00 to $343.00, depending on the complexity of the visit. All forms of payment are accepted - including Care Credit. ***Please bring your insurance card(s)*** with you for all visits.

**PARKING**: Parking is available in the 'Grant-Molett Medical Arts Plaza' parking lot with direct access to the front entrance of our office. Handicap parking spaces are provided directly in front of the medical office entrance.

We look forward to seeing you.

Thank you.

# FINANCIAL POLICY

Thank you for choosing us as your health care provider. Acadiana Gastroenterology Associates, LLC and Acadiana Endoscopy Center, Inc. are committed to making healthcare less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our financial policy which we ask that you **read and sign where indicated below** prior to your initial office visit or procedure.

**INSURANCE AND PAYMENT POLICY:** Your insurance policy is a contract between you and your insurance company. OFFICE VISITS: It is very important that you contact your insurance prior to the initial office visit in order to assure that the attending Physician is covered on your plan or participating within your insurance's network. By doing so, your insurance will inform you if a referral is required or if there are any out of pocket expenses such as co-pays, co-insurance or deductibles. We are not a party of that contract. PROCEDURES: As a courtesy, the attending Physician's office obtains pre-certification (if necessary) for procedures at our Facility – Acadiana Endoscopy Center, Inc. Pre-certification of your procedure does not guarantee payment for services provided. **It is the patient's responsibility to verify benefits with his / her insurance**, determine if the scheduled procedure is a covered service, and to know the extent of his or her coverage(s) for services provided by the attending Physician and the Facility.

Filing your insurance is a COURTESY ONLY. Our office policy allows 45 days for insurance payment. Please note: After 45 days, you are responsible for the bill regardless of what the status is of the insurance. Payment arrangements should be made with our office prior to your scheduled procedure. All outstanding patient balances over 120 days from the original date of service without payment arrangements made will be turned over to a collections agency. If **MEDICARE / CMS** is your primary insurance, we will file all claims and accept assignment for related services. Any **deductibles and/or co-insurance are due and payable at the time of service**.

**PAYMENT METHODS:** We accept all forms of payment including Care Credit. **There will be a $25.00 fee for all returned checks**. 'Self Pay' patients are required to pay - or make payment arrangements - for covering the estimated charges prior to any scheduled procedure.

**BILLING STATEMENTS (Physician, Facility, Pathology and Anesthesia fees):** If you will be having a procedure performed by one of the Physicians of Acadiana Gastroenterology Associates, please be aware that **YOU WILL RECEIVE SEPARATE BILLING STATEMENTS** for other services provided depending on where your procedure is performed. You will receive a statement from **Acadiana Gastroenterology Associates, LLC** for the Physician's professional services. If your procedure is performed at **Acadiana Endoscopy Center, Inc**., you will receive a statement for Facility charges billed by Acadiana Endoscopy Center, Inc. You may also receive a statement from **Inform Diagnostics** for pathology services if biopsies (tissue specimens) or polyps are removed during your procedure. Depending upon your sedation plan, you may also incur an anesthesia charge from **Precision Anesthesia of Lafayette, LLC** for IV anesthesia services provided. If your procedure is scheduled and performed in a hospital setting, you will receive similar statements but from other service providers. If you have any questions, please call before your scheduled visit or ask any of our front office staff on the day of your appointment.

**SCREENING COLONOSCOPY VS. DIAGNOSTIC COLONOSCOPY COVERAGE:** Insurance companies will often provide SCREENING BENEFITS for routine screening colonoscopy. However, if the Physician removes a polyp or performs biopsy during your screening procedure, the procedure may be considered 'diagnostic' and may not be covered as a screening exam. If this were to occur, some insurance companies make the patient financially responsible for all or part of the procedure cost. Please refer to your individual policy terms, conditions, and coverage regarding these benefits.

**CANCELLATION POLICY – ACADIANA ENDOSCOPY CENTER, INC:** Your time and care is very important to us. In order for our Facility to provide exceptional care and accommodate the needs of our patients as efficiently as possible, certain 'block-time' requirements have been established for each patient's procedure type. Therefore, we require sufficient notice in the event of a cancellation and / or rescheduling of a procedure in order that we may accommodate other patient's needs. Please note: The Facility of Acadiana Endoscopy Center, Inc. requires a **3 day notice (Three Business Days) for cancellations of all procedures. Acadiana Endoscopy Center, Inc. will assess a $100.00 'late cancellation' fee** towards the patient's account if notice is not received before the 3 business day limit. This fee will not be covered by your insurance company. Therefore, the fee will be billed directly to the patient. We ask that you or a family member call our Center at (337) 269-1126 between the hours of 7:00 am – 2:00 pm, Monday through Friday, for cancellations or to reschedule your procedure.

**ACKNOWLEDGEMENT:** I hereby authorize Acadiana Endoscopy Center, Inc. and Acadiana Gastroenterology Associates, LLC to furnish information to my insurance company concerning my illness and treatment for payment purposes. I hereby assign Acadiana Endoscopy Center, Inc. and Acadiana Gastroenterology Associates, LLC all payments for medical services rendered to myself or dependents. I understand that I am responsible for all charges for services rendered regardless of insurance coverage.

_____ _____

*Signature of Patient / Acknowledgement (or Parent if Patient is a minor* *Date:*

_____

*Printed Name of Patient*

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Dear Patient,

Please read and acknowledge by signature below. Thank you.

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**DISCLOSURE OF OWNERSHIP:**

As required by law, a Physician must disclose to their patients any ownership that he or she maintains in a medical facility, specifically, when a patient of that same physician may potentially have services performed at said facility. Therefore, please note that the following Physician members of Acadiana Gastroenterology Associates, LLC have ownership interests in the named entities, Acadiana Endoscopy Center, Inc. and Precision Anesthesia of Lafayette, LLC, both with business addresses of 443 Heymann Blvd., Lafayette, Louisiana 70503; Stephen M. Person, M.D., J. Patrick Herrington, M.D., James C. Bienvenu, M.D., Richard K. Broussard, M.D., Erick A. Salvatierra, M.D., Patrick A. Laperouse, M.D. and Christopher P. Herrington, M.D.

**AUTHORIZATION AND RELEASE:**

Insurers and Managed Care Companies occasionally review medical charts to insure compliance with company procedures. The National Committee on Quality Assurance (NCQA) and most 'payors' request periodic reviews during the re-credentialing process. I understand that my medical record may be selected for such review and that the confidentiality of the information in my medical record will be preserved. I hereby consent to such review and release this physician and any such Insurer or Managed Care Company for liability for any reasonable review of my medical record. This authorization will be a part of my permanent record.

_____ _____

Signature of Patient: Date:

_____

Printed Name of Patient:

# PATIENT INFORMATION

Patients Full Name: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Mobile Number: _____ Home Number: _____ Work Number: _____

Married: _____ Single: _____ Widowed: _____ Divorced: _____ Separated: _____ Live with parents: _____

Referring Physician Name: _____

Primary Care Physician Name: _____

**IF MARRIED OR MINOR, Please Fill Out The Following Information**:

Full Name of Your Spouse or Guardian: _____ Relation: _____ Phone: _____

Social Security Number of Spouse or Guardian: _____ Office Phone: _____

**INSURANCE COVERAGE:**

**MEDICARE #**: _____ (Primary _____ Secondary _____) **MEDICAID #**: _____

***PRIMARY***

Name and Address of Company: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Date of Birth: _____

Group #: _____ Policy #: _____ Effective Date of Coverage: _____

***SECONDARY***

Name and Address of Company: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____ Date of Birth: _____

Group #: _____ Policy #: _____ Effective Date of Coverage: _____

**NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient or Authorized Signature:

I authorize the release of any medical information to process this claim and payment of medical benefits to undersigned physician or supplier for service described. I request that payment of authorized Medicare benefits be made either to me or on my behalf to the physician for any services furnished me by that provider. I authorize any holder of medical information about me to release to CMS – Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Should your account be referred to a collection agency for collection, you will be responsible for all collection and/or attorney fees incurred.

**Signed**: _____ **Date**: _____

*Signature of Patient or Authorized Representative*

*** There Will Be a $25.00 Service Charge On All NSF Checks. ***

*** **ALL SERVICES ARE PAYABLE AT THE TIME OF VISIT** ***

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## 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

**Preferred Language**

☐ English ☐ French ☐ Spanish; Castilian ☐ Patient declines to specify

**Contact Preference**

☐ Letter ☐ Email ☐ Cell phone ☐ Telephone call-Work ☐ Telephone call - Home

☐ Patient declines to specify Other:_____

### Social History

Occupation:_____ Number of Children:_____

**Marital Status**

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Civil Union ☐ Unknown ☐ Other

**Alcohol**

- ☐ None
- ☐ Less than 7 per week
- ☐ More than 7 per week
- Type:_____

**Caffeine**

- ☐ None
- ☐ Coffee
- ☐ Soft Drinks
- ☐ Energy Drinks

Intake:_____

**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
- ☐ Uses IV drugs currently
- ☐ Used IV drugs in the past
- ☐ Recreational drug use

**Exercise**

- ☐ None

| Type | Quantity | Number | Frequency |
|---|---|---|---|
| | | | |

## Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Penicillins
- ☐ Codeine
- ☐ Morphine
- ☐ Sulfa
- ☐ Latex
- ☐ IV Dye, Iodine Containing
- ☐ Milk
- ☐ Adhesive Tape
- ☐ Demerol
- Other:_____

## Current Medications

- ☐ None

| Name | Dose | How taken? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Immunizations

- ☐ None

- ☐ Influenza, seasonal, injectable — When:_____
- ☐ Pneumonia vaccine — When:_____
- ☐ Shingles vaccine — When:_____
- ☐ Hep B — When:_____
- ☐ PPD — When:_____

## Diagnostic Studies/Tests

- ☐ None

- ☐ EGD
- ☐ Colonoscopy
- ☐ ERCP
- ☐ CT Abdomen/Pelvis
- ☐ Abdominal Ultrasound
- ☐ Liver Biopsy
- ☐ HIDA / CCK Scan
- ☐ EUS
- ☐ Flexible Sigmoidoscopy
- ☐ Fecal Occult Blood Test
- ☐ Abdominal x-ray

## Past or Present Medical Conditions

- ☐ None

| | | | | |
|---|---|---|---|---|
| **Blood** | ☐ Anemia | ☐ Lymphoma | ☐ Leukemia | |
| **Cardiovascular** | ☐ Atrial Fibrilation | ☐ Congestive Heart Failure | ☐ High blood pressure | ☐ Myocardial infarction - Heart Attack |
| **Circulation** | ☐ Coronary Artery Disease | ☐ Deep vein thrombosis | ☐ Peripheral Vascular Disease | ☐ Pulmonary embolus |
| **Endocrine** | ☐ Diabetes Mellitus, Non-Insulin Dependent<br>☐ Thyroid Disorder | ☐ Diabetes Mellitus, Insulin Dependent | ☐ Elevated cholesterol | ☐ Osteoporosis |
| **Gastrointestinal** | ☐ Barrett's Esophagus | ☐ Crohn's Disease | ☐ Helicobacter pylori-associated gastritis | ☐ Pancreatitis |
| | ☐ Celiac Disease | ☐ Diverticulosis | ☐ Irritable Bowel Syndrome | ☐ Gastric ulcer |
| | ☐ Cirrhosis | ☐ GERD/reflux | ☐ Lactose Intolerance | ☐ Hepatitis A |
| | ☐ Hepatitis B | ☐ Hepatitis C | ☐ Disease of liver | ☐ Ulcerative Colitis |
| | ☐ Colon polyp history | ☐ Colon cancer | ☐ Pancreatic Cancer | ☐ Blood in stool |
| **Pulmonary** | ☐ Asthma | ☐ Emphysema | ☐ C.O.P.D. | |
| **Neurology** | ☐ Dementia | ☐ Epilepsy | ☐ Parkinson's Disease | ☐ Stroke |
| **Psychiatric** | ☐ Anxiety disorder | ☐ Bipolar disorder | ☐ Depression | |
| **Rheumatology** | ☐ Fibromyalgia | ☐ Lupus | ☐ Rheumatoid arthritis | |
| **Urinary** | ☐ Enlarged Prostate (BPH) | ☐ Kidney Failure | ☐ Kidney stones | ☐ Prostate Cancer |
| **Other** | ☐ Back Pain (chronic ) | ☐ Glaucoma | ☐ Sleep Apnea | |
| **Cancer** | ☐ Type | | | |

## Previous Procedures

- ☐ None

- ☐ Hysterectomy
- ☐ Appendectomy
- ☐ Gallbladder Removal
- ☐ C-Section
- ☐ Coronary Artery Stent
- ☐ Bypass Graft (CABG)
- ☐ Hernia Repair
- ☐ Hemorrhoidectomy
- ☐ Joint Replacement
- ☐ Prostate Surgery
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Bowel Surgery
- ☐ Weight Loss Surgery
- ☐ Thyroidectomy - Total

## Family Medical History

☐ No knowledge of family history

**No family history of**

- ☐ Celiac Disease
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Liver Disease
- ☐ Ulcerative colitis

| Diagnoses | Mother | Father | Sister | Brother | Daughter | Son | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Celiac disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Polyps | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Irritable bowel syndrome | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Liver disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Pancreatic Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Ulcerative colitis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Crohn's disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Gallbladder Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

## Review Of Systems

**Cardiovascular**

| None | Y | N |
|---|---|---|
| chest pain | ○ | ○ |
| palpitations | ○ | ○ |
| peripheral edema | ○ | ○ |

**Constitutional**

| None | Y | N |
|---|---|---|
| fatigue | ○ | ○ |
| fever | ○ | ○ |
| loss of appetite | ○ | ○ |
| weight loss | ○ | ○ |

**ENMT**

| None | Y | N |
|---|---|---|
| ear pain | ○ | ○ |
| nasal obstruction | ○ | ○ |
| nose bleeds | ○ | ○ |
| hearing loss | ○ | ○ |

**Endocrine**

| None | Y | N |
|---|---|---|
| excessive thirst | ○ | ○ |
| heat intolerance | ○ | ○ |

**Eyes**

| None | Y | N |
|---|---|---|
| loss of vision | ○ | ○ |

**Gastrointestinal**

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

**Genitourinary**

| None | Y | N |
|---|---|---|
| dark urine | ○ | ○ |
| dysuria | ○ | ○ |
| frequent urination | ○ | ○ |
| hematuria | ○ | ○ |

**Hematologic/Lymphatic**

| None | Y | N |
|---|---|---|
| easy bruising | ○ | ○ |
| prolonged bleeding | ○ | ○ |

**Integumentary**

| None | Y | N |
|---|---|---|
| itching | ○ | ○ |
| jaundice | ○ | ○ |
| rashes | ○ | ○ |

**Musculoskeletal**

| None | Y | N |
|---|---|---|
| back pain | ○ | ○ |
| joint pain | ○ | ○ |
| muscle weakness | ○ | ○ |

**Neurological**

| None | Y | N |
|---|---|---|
| dizziness | ○ | ○ |
| fainting | ○ | ○ |
| frequent headaches | ○ | ○ |
| memory loss | ○ | ○ |

**Psychiatric**

| None | Y | N |
|---|---|---|
| anxiety | ○ | ○ |
| depression | ○ | ○ |

**Respiratory**

| None | Y | N |
|---|---|---|
| cough | ○ | ○ |
| dyspnea | ○ | ○ |
| excessive sputum | ○ | ○ |
| coughing up blood | ○ | ○ |
| wheezing | ○ | ○ |

## Pharmacy

Name Address Phone

## Consent to Import Medication History

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

○ Yes ○ No

## Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present