LOUISIANA GASTROENTEROLOGY ASSOCIATES LLC

Your office visit is scheduled on _____. Please arrive at_____.

You will be seeing _____

_____ Lab work Needed prior to appointment
(Orders Attached- Please complete 1 week prior to Apt)

_____ Non Fasting _____ Fasting

At	**The Gastro Clinic**	**1211 Coolidge Blvd Ste 303**	**Lafayette LA 70503**
	The Gastro Clinic	**1211 Coolidge Blvd Ste 400**	**Lafayette LA 70503**
	Acadiana Gastro Associates	**439 Heyman Blvd**	**Lafayette LA 70503**

3rd Floor Abbeville General Specialty Clinic	**118 N Hospital Drive**	**Abbeville LA 70510**
Abbeville Clinic- Lahasky Medical Center	**2621 North Drive**	**Abbeville LA 70510**
Abrom Kaplan Specialty Clinic	**711 Montgomery Drive**	**Kaplan LA 70548**
Breaux Bridge Specialty Clinic	**1555 Gary Drive**	**Breaux Bridge LA 70517**

CANCELLATION NOTICE- THE GASTRO CLINIC REQUIRES A 48HR CANCELLATION NOTICED BEFORE SCHEDULED APPOINTMENT. THERE IS A NO SHOW FEE OF $100 FOR ALL OFFICE VISITS AND $200 FEE FOR PROCEDURES. **

Hand carry any medication you currently take. Include prescriptions and over the counter medication such as vitamins, herbal supplements, pain relievers, etc.

Hand carry your insurance card(s) and a pictured I.D. These are needed for each visit.

If you have any questions, my name is _____, please feel free to contact me.

the Gastro CLINIC
www.gastroclinic.com
Phone 337-232-6697
Fax 337-232-3147

AGA
www.acadianagastro.com
(337) 269-0963 - Main Line
(337) 269-0553 - Fax

PATIENT INFORMATION

Name _____ Date of Birth: _____

Sex _____ Race: _____ Marital Status: _____ SS# _____

Mailing Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Mobile Phone : _____

Email Address _____

Employer _____ Occupation _____

Emergency Contact (Name of friend or relative **NOT** living with you) _____

Home Phone _____ Additional Phone _____ Relationship _____

Address (if known) _____

Referring Physician _____ Primary Care Physician: _____

Pharmacy Name/Location _____ Pharmacy Phone _____

INSURANCE INFORMATION

(PLEASE BRING INSURANCE CARDS AT TIME OF APPOINTMENT SO WE CAN SCAN INTO YOUR CHART FOR BILLING)

☐ Check box if Guarantor is self (no need to fill out section) Guarantor is the person responsible for the bill after insurance pays.

Name of Guarantor: _____ Phone _____

Address _____

PATIENT HEALTH INFORMATION PRIVACY AND SECURITY

I have received a copy of this office's Notice of Privacy Practices.

You may disclose my health information to the following people:

Name	Relationship	Number to reach them if we are unable to reach you

****If no one is listed we cannot give out any information to anyone other than you****

Please check your preferred method of contact: (check all that apply)

❑ Home phone ❑ Voice mail message ❑ Work phone ❑ Cell phone

Is there anyone other than yourself that you prefer us to speak to regarding insurance and billing?

❑ Yes ❑ No

If yes, please state name, relationship and phone number:

Name: _____ Relation: _____ Phone: _____

Financial Policy We will file all insurance for you. If there is any balance owed after the insurance pays and after what you have paid today we will bill to you. We expect payment in full upon receipt of your statement unless prior arrangements have been made with the office. If no payment is received after 90 days we turn over unpaid balances to a collection agency. If we owe you money, refunds are done once a month at the end of every month. We do not refund anything under $5.00. Any questions in regards to our financial policy please ask for our Business Office Manager. **Pt /Guardian Initials** _____

Patient or Legal Guardian Signature _____ Date _____

CONSENT FOR TREATMENT AND FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Louisiana Gastroenterology Associates, LLC creates and maintains health records describing my health history. I understand the Louisiana Gastroenterology Associates, LLC may use this information as:

1. A basis for planning my care and treatment,
2. A means of communication among many health professionals who contribute to my care,
3. A means by which third-party payers can verify that services billed were actually provided,
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals, and
5. A means by which licensing, accreditation, and regulatory agencies can verify that appropriate quality services are provided.

I consent to treatment at Louisiana Gastroenterology Associates, LLC., their associates, partners, assistants, or designees. I consent to any or all outpatient care, which encompasses the following as ordered by my physician: interview, physical examination, x ray examination or fluoroscopy, laboratory procedures, diagnostic procedures, conscious sedation or local anesthesia, and nursing or medical treatment which my physician may deem necessary or advisable.

I consent to the use and disclosure of my personal health information by Louisiana Gastroenterology Associates, LLC. for the purposes of treatment, payment, and healthcare operations. I authorize Louisiana Gastroenterology Associates, LLC to apply for benefits on my behalf of covered services. I request payment from my insurance company be made directly to Louisiana Gastroenterology Associates, LLC.

Patient Signature: _____ Witness: _____

If patient is a minor or unable to sign:

Patient Representative: _____ Relationship: _____

Printed Name of Patient: _____ Date: _____

Louisiana Gastroenterology Associates, LLC

OFFICE POLICY

Welcome to Louisiana Gastroenterology Associates. We appreciate you choosing us for your healthcare. The following is a list of guidelines necessary to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. It is your responsibility to present your correct insurance card and pictured ID at each visit for us to bill your insurance.
2. You will be asked to provide us with up-to-date health information at each visit so we can treat your health issues as a priority.
3. If you have a change of address, telephone number, employer, etc., please notify us as soon as the changes occur.
4. Louisiana Gastroenterology Associates is a specialty consultant clinic; our providers are NOT primary care providers.
5. We collect deductible, co-payment, or charge for non-covered services at the time of visit. If you have a balance after an insurance payment from a previous service, we also ask for that payment. We accept cash, checks, Visa, MasterCard, and Discover.
6. **Medicare Patients:** We are participating providers with Medicare and bill Medicare on your behalf. If you have supplemental insurance, we will bill that for you also. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at time of service. Each year you will pay the allowed amount of charges until your deductible is met.
7. **Insurance covered Patients with plans we participate in:** If we participate with your plan, we bill your insurance for you. Your co-payment/co-insurance will be collected at time of service - no exceptions. If your plan requires you to have an authorization to see a specialist, YOU will need to obtain the authorization from your PCP.
8. **Insurance covered Patients with plans we do not participate in:** If we do not participate with your plan, we will verify your out-of-network benefits, file your charges, and will expect payment of your portion of the charges at the time of service.
9. If insurance denies charges and/or does not pay your claim within 60 days, we have the right to turn the entire balance over to you.
10. **Self-Pay Patients:** *Established* patients with no insurance will be expected to pay at time of service.
    New self-pay patients must put down a $250 deposit prior to scheduling any appointments.
11. **Procedures Scheduled:** You will be required to pay your portion of the physician charges at least 48 hours prior to the day of the procedure scheduled. Failure to pay may result in cancellation of your procedure.
12. **Screening Colons:** During your screening colonoscopy if a biopsy, polypectomy, or snare procedure needs to be done, then the procedure changes from a screening to a therapeutic procedure. Your insurance may pay in a different manner.
13. If your account becomes delinquent, we reserve the right to refer your account to a collection agency to be reported to the credit bureau. Any fees assessed by the collection agency will be the patient's responsibility. Delinquent account refers to non-payment 90 days after the balance becomes your responsibility.
14. Be aware you will receive separate charges from the Provider (Louisiana Gastro Assoc.), Facility (ex. TEC or AEC), Pathology and/or Anesthesiology, etc. depending on your procedure.
15. **No Shows or Missed Appointments**: An appointment scheduled with the provider is time specifically allocated for you. No show charges may be applied and are not filled with insurance.
    - Failure to cancel *clinic visits* 24 hours in advance will result in a $100 charge.
    - Failure to cancel *procedures* 48 hours in advance will result in a $200 charge.
16. NSF (returned checks) will result in a $35 charge to the patient, this is not filed with your insurance.
17. If overpayment/underpayment is $5.00 or less, we will not refund/bill these amounts. Refunds are processed once a month.
18. The MD has discretion to discharge the patient back to primary physician at any point once specialty concerns have been addressed.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding this office policy, please feel free to contact us at www.gastroclinic.com.

I have read and have a full understanding of the policies of Louisiana Gastroenterology Associates.

_____	_____
Patient	Date
_____	_____
Representative Signature	Relationship to Patient
_____	_____
Witness	Guarantor Signature Required (For Minor in non-emergent situation)

Patient Name: _____ Date: _____

Please provide a list of all of your current medications including prescriptions, over the counter, vitamins, or herbal supplements.

Medication Name:	Strength:	How many times a day:
Example: Nexium	40mg	One tablet every morning

Allergies: _____