AUTHORIZATION TO OBTAIN HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names _____ Birth Date/Medical Record Number _____

Street Address _____ City, State, Zip _____

INFORMATION RELEASED FROM:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

INFORMATION RECIEVED BY:

Tri-State Gastroenterology Associates

425 Centre View Blvd
Crestview Hills, KY 41017

Phone: 859-341-3575
Fax: 859-341-5701

INFORMATION TO BE RELEASED:

For the Following Date(s): _____

___ Medical History, Examination, Reports
___ Treatment or Tests
___ Allergy Records
___ Consultations
___ Other (Specify): _____
___ Surgical Reports
___ Hospital Records Including Reports
___ Laboratory Reports
___ Entire Record
___ Immunizations
___ X-ray Reports
___ Prescriptions

In compliance with Ky. Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

___ Mental Health
___ HIV (AIDS)
___ Other (Specify): _____
___ Developmental Disabilities
___ Sexually Transmitted Disease
___ Alcoholism
___ Drug Abuse

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___ Further Medical Care
___ Insurance Eligibility/Benefits
___ Other (Specify): _____
___ Legal Investigation or Action
___ Changing Physicians
___ Personal

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Office of Tri-State Gastroenterology Associates. Right to Receive Copy of This Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to Withdraw This Authorization - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: the Privacy Officer for Tri-State Gastroenterology Associates. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for 90 Days from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ DATE: _____

(If signed by other than patient, state relationship and authority to do so.)

WITNESS: _____

TRI-STATE GASTRO

Tri-State Gastroenterology Associates
425 Centre View Boulevard
Crestview Hills, KY 41017
859-341-3575

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

☐ Phone- Can leave a message on any number ☐ Home # ☐ Cell # ☐ Cell 2 # ☐ e-mail/ patient portal

☐ Patient declines to specify Other: _____

Pharmacy

Name Address Phone

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Latex
- ◯ Adhesive Tape
- ◯ midazolam / versed
- ◯ Sulfa (Sulfonamide Antibiotics)
- ◯ Benadryl Allergy
- ◯ Aspirin (Tartrazine Only)
- ◯ Penicillins
- ◯ Demerol
- ◯ fentanyl citrate
- ◯ benzocaine

Other: Other: Other: Other:

Current Medications

◯ None

Name Dose How taken?

Immunizations

◯ None

- ◯ Hep A, adult When:
- ◯ Hepatitis B When:
- ◯ PPD When:
- ◯ Pneumococcal When:
- ◯ Zoster /Shingles When:
- ◯ Flu vaccine When:

Past or Present Medical Conditions

◯ None

CARDIOVASCULAR

- ◯ CVA / Stroke within the last 12 months Date:
- ◯ CVA/ Stroke occurring greater than 12 months
- ◯ Heart attack / Acute MI within the last 6 months - - Date:
- ◯ Heart attack /Acute MI greater than 6 months
- ◯ Coronary Artery Disease
- ◯ Congestive Heart Failure
- ◯ Hypercholesterolemia
- ◯ High blood pressure
- ◯ Valvular heart disease
- ◯ Atrial Fibrillation
- ◯ Chest pain

PULMONARY

- ◯ Emphysema
- ◯ Asthma
- ◯ COPD
- ◯ Obstructive Sleep Apnea / does not use cpap

GASTROINTESTINAL

- ◯ GERD
- ◯ Anemia
- ◯ Barrett's Esophagus
- ◯ Inflammatory Bowel Disease
- ◯ Colon Polyps
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ IBS / Irritable Bowel Syndrome
- ◯ Pancreatitis
- ◯ Cirrhosis
- ◯ Celiac Disease
- ◯ Diverticulosis
- ◯ Dysphagia

CANCER

- ◯ Colon cancer
- ◯ Rectal Cancer
- ◯ Pancreatic Cancer
- ◯ Prostate Cancer
- ◯ Lung Cancer
- ◯ Breast Cancer
- ◯ Leukemia
- ◯ Ovarian Cancer

	◯ Bladder Cancer	◯ Testicular Cancer	◯ Head & Neck Cancer	◯ Melanoma
OTHER	◯ Diabetes Mellitus	◯ Kidney Disease	◯ Thyroid Disease	◯ Seizures
	◯ Neurologic Disorder	◯ Arthritis (Osteoarthritis / Rheumatoid)	◯ Anxiety disorder	◯ Depression
	◯ H.I.V.			

Diagnostic Studies/Tests

◯ None

◯ EGD When:_____ ◯ Colonoscopy When:_____ ◯ Abdominal x-ray When:_____ ◯ Chest X-Ray When:_____ ◯ Stress Test When:_____

◯ MRI Abdomen/Pelvis When:_____ ◯ Abdominal Ultrasound When:_____ ◯ Lab work When:_____

Previous Procedures

◯ None

◯ Angioplasty ◯ Appendectomy ◯ Colostomy ◯ Coronary Artery Bypass Graft (CABG) ◯ C-Section

◯ Defibrillator Placement ◯ Gall bladder Removed-Cholecystectomy ◯ Gastric Bypass - type unspecified ◯ Pacemaker Insertion ◯ Mastectomy

◯ Hernia Repair - site unspecified

Social History

Occupation:_____ Number of Children:_____

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

◯ Unknown ◯ Other

Alcohol

◯ None

Type Quantity

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

Type

Quantity

Family Medical History

◯ No knowledge of family history

No family history of

◯ Celiac Sprue
◯ Colon polyps
◯ Pancreatic Cancer
◯ Colon cancer
◯ Crohn's Disease
◯ Ulcerative Colitis

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather	Aunt	Uncle
Colon Cancer	○	○	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○	○	○
Barrett's Esophagus	○	○	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○	○	○
Bladder Cancer	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Consent to Import Medication History

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

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

Yes No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

I consent to having my medical and demographic information shared with other health care entities.

Yes No

Signature

Signature Date

Tri-State
Gastroenterology
Associates

425 Centre View Blvd
Crestview Hills, KY 41017
(859) 655-4565 Phone
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www.tristategastro.com

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Allan P. Lam, DO

Karen L. Ruschman, APRN
Briana Goodridge, APRN
Allison M. Kreate, APRN
John W. Biery JR, APRN
Carolyn R. Monroe, APRN

PATIENT INFORMATION		
Name:	Date of Birth:	Today's Date:

Thank you for choosing us as your health care provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is important. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Regarding Insurance:
As a courtesy our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us correct insurance information. **It is your responsibility to inform us if your insurance has changed at any time during treatment.** Please understand that your bill is ultimately your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full in a timely manner, it will then become your responsibility to pay the balance. We accept Cash, Check, Visa and MasterCard. An account over 90 days old without payment is subject to being sent to a collection agency/small claims court.

*****All co-pays are due at the time of visits. *****

Referrals and Pre-authorizations:
If your insurance company requires a referral from your primary care physician, you must present this to our staff before being seen. If you do not obtain a referral when your insurance requires one, you will be required to pay in full for the visit or service. It is your responsibility to obtain a referral.

Missed Appointments and Cancellation Fee:
Due to the amount of time allotted for scheduled endoscopic procedures, we do request at least 3 working days' notice for cancellation of any procedures. **It is our policy to charge a $100.00 cancellation/no show fee if given less than 3 working days' notice. Also it is our policy to Charge a $40.00 cancellation/no show fee for any office visit that is not cancelled 1 working day prior to that scheduled visit.** The charge for a late cancellation/no show fee will be billed directly to you and not to your insurance company. Please help us serve you better by keeping scheduled appointments.

Insurance Release Information:
I hereby authorize the office of Tri-State Gastroenterology Associates, to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to Tri-State Gastroenterology. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. **If I default in payment I understand that I will be responsible for any collection fees up to 30% and legal fees.**

Signature of Patient/Guardian

Date

TSDDC/TSGA ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been offered the Privacy Practices Notice.
(Available at www.tristategastro.com or in the office)

_____

Patient or Personal Representative's Printed Name

_____

Patient or Personal Representative's Signature

If Personal Representative's signature appears above, please describe relationship to patient_____

PATIENT RECORD OF DISCLOSURES

I, _____give my permission to discuss my PHI with the following person (s):

NAME	RELATIONSHIP
1._____	_____
2._____	_____
3._____	_____

I wish to be contacted in the following manner (check all that apply)

Home Telephone_____
Cell Phone_____
_____OK to leave detailed message
_____ Leave a call back number

Written Communication
_____OK to mail medical information to the home address

Work Telephone number
_____OK to leave detailed message
_____Leave a call back number

E-mail address_____
_____OK to leave medical info & appts
_____Include name/number to office call back

*If any of this information should change, it is your responsibility as our patient to notify TSDDC/TSGA of these changes as soon as possible.

_____ _____

Signature Date

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Scott C. Leverage, MD
Joel M. Warren, MD

Jessica Gardner, PA-C
John Biery, Jr, APRN

Financial Expectations

Consistent with this Policy and the Financial Assistance Policy, Tri-State Gastroenterology Associates will clearly communicate with patients regarding financial expectations as early in the appointment and billing process as possible.

• Patients are responsible for understanding their insurance coverage and for providing needed documentation to aid in the insurance collection process.

• Patients may be required to pay a pre-service deposit or estimated co-pays and deductibles prior to services (except in emergent situations) or amounts may be collected after services are provided, based on the current business practices of Tri-State Gastroenterology.

• Patients are generally responsible for paying self-pay balances, including any amounts not paid by insurance companies or applicable third party payers.

• If the patient has a previous bad debt or outstanding balance, Tri-State Gastroenterology may request amounts owed before future appointments are granted. If arrangements cannot be made for resolving the patient's outstanding balance, future non-emergency care may be limited or denied. Pre-service deposits may be required for non-emergency services.

• Tri-State Gastroenterology will make every attempt to contact patients prior to services and procedures being rendered to notify of financial liability. If any questions, please contact Sara Smith, Financial Counselor, 859-655-4561.

Directions to:

Tri-State Gastroenterology Associates

425 Centre View Blvd.

Crestview Hills, KY 41017

From I-75 North or South, take I-275 East (in Kentucky) to the Turkeyfoot Road exit and go south on Turkeyfoot Road. Turn left onto Thomas More Parkway. Turn left onto Centre View Blvd at the stop light. Go to the first stop sign where Centre View Blvd and Chancellor Drive meet. Our building is on the right corner. It is the only building with a green roof.

From I-275 in Kentucky, take the Turkeyfoot Road exit and go south on Turkeyfoot Road. Turn left onto Thomas More Parkway. Turn left onto Centre View Blvd at the stop light. Go to the first stop sign where Centre View Blvd and Chancellor Drive meet. Our building is on the right corner. It is the only building with a green roof.

We are Building #17:

- If you have an office appt: Come to our upper level entrance
- If you have a Procedure: Turn left into our parking lot, drive in front of the building, lot will circle down to the lower parking – Go in doors under overhang.

Thank you for choosing Tri-State Gastroenterology!