



PREMIER

GASTROENTEROLOGY

TERENCE L. ANGTUACO MD ANGELO G. COPPOLA MD BRIAN T. HUGHES MD R. STEVEN JONES MD
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Welcome to Premier Gastroenterology!

Thank you for choosing to help manage your healthcare. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner, and we are excited to welcome you to the Premier Family.

For your first appointment please plan to arrive 30 minutes early to check in and complete any necessary paperwork. After you arrive at the clinic your physician will spend time reviewing your medical history, discussing your symptoms and performing a physical examination, so please schedule extra time for these activities. In addition, it is possible that you might have blood drawn or additional tests performed.

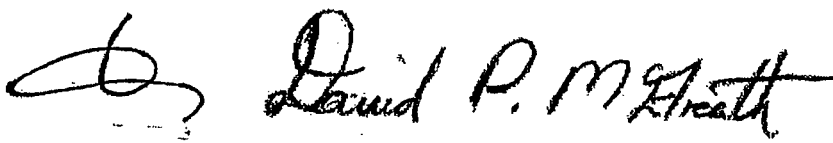

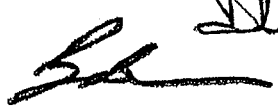
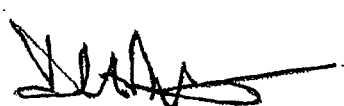
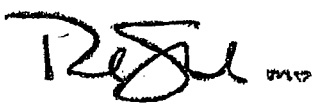
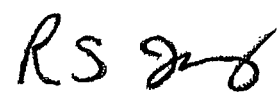
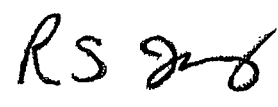
Please bring your insurance information and a photo ID with you for each appointment. If you are unable to provide us with your insurance information, your appointment may need to be rescheduled. If you haven't already done so, you will be asked to fill out new patient paperwork.

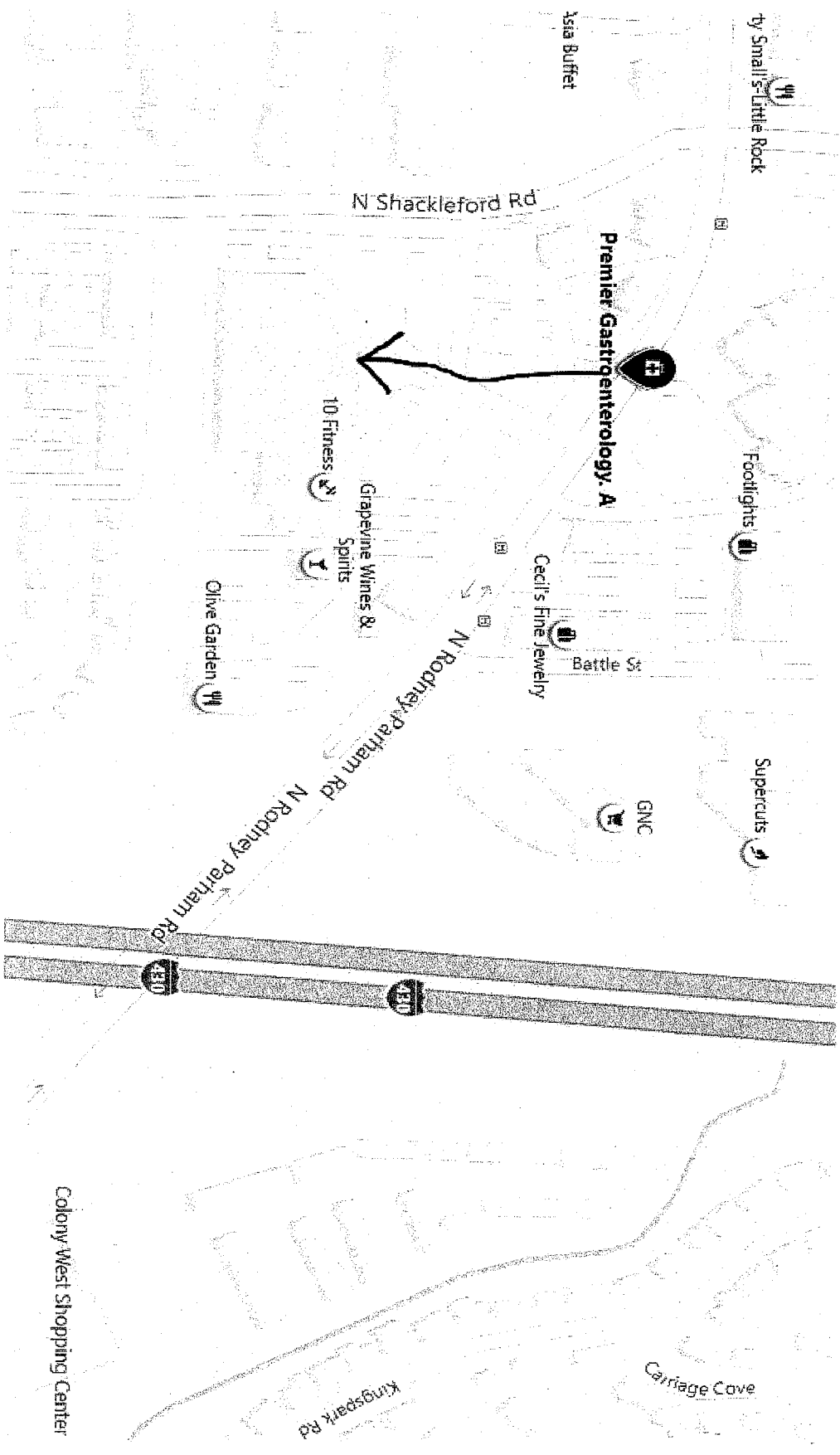
All co-pays and past due balances are expected at time of service unless a prior agreement has been made with our billing department. You should receive a copy of our financial policy prior to your visit.

Please allow plenty of time to get to the office for your appointment. We strive to stay on time, however from time to time a delay might occur that affects your visit. You will have the option to re-schedule or stay. Should you choose to stay, we will keep you notified as to your wait time.

Thank you again for choosing Premier Gastroenterology. We look forward to seeing you soon, and if you have any questions prior to your visit, please do not hesitate to call our office.

Sincerely,



10915 N Rodney Parham Rd, Little Rock, AR 72212

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: _____

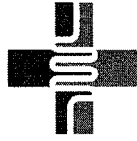
Policy Holder: _____ Relationship: _____ SSN: _____

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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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 the 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

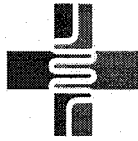
Signature of Witness

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

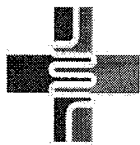
Date of Birth

Signature of the Individual Giving this Authorization

Date

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





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GASTROENTEROLOGY

PATIENT NAME: _____ DATE OF BIRTH _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

****UPDATED 5/14/2020****

1. _____ (Patient/Guardian Initials) **Financial Agreement.** I acknowledge, that as a courtesy, Premier Gastroenterology Associates bill my insurance company for services provided to me. 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 and/or deductible, or charges not covered by insurance. I understand that there is a \$25.00 fee for returned checks.

2. _____ (Patient/Guardian Initials) **Cancellations and/or No-Show Appointments.** If you do not cancel your appointment with at least 24 hours' notice before, or fail to show up for an appointment, you will be charged a fee of \$30.00. And, if you do not cancel your appointment with 72 hours' notice or more, or fail to show up for a procedure, you will be charged a fee of \$100.00.

3. _____ (Patient/Guardian Initials) **Assignment of Benefits.** I hereby assign to Premier Gastroenterology Associates any insurance or third-party benefits available for health care services provided to me. I understand Premier Gastroenterology Associates has the right to refuse or accept 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. _____ (Patient/Guardian Initials) **Consent to Telephone Communications.** I agree that, in order for Premier Gastroenterology Associates, and collection agents, to service my account or to collect any amount I may owe, I expressly agree and consent that Premier Gastroenterology Associates any or collection agents 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. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient/Patient Representative Signature :

X _____ Date _____

If you are not the patient, please identify your relationship to the patient. (Circle or mark relationship from below)

Spouse Guarantor Parent Healthcare Power of Attorney Legal Guardian Other (please specify)



10915 N. Rodney Parham, Suite 1
Little Rock, AR 7221
(501) 747-282

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

Diagnostic Studies/Tests

None

- Colonoscopy
 EGD
 CT Abdomen/Pelvis
 MRI Abdomen/Pelvis
 Abdominal Ultrasound
- When: _____
 When: _____
 When: _____
 When: _____
 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
 Colon cancer
 Irritable Bowel Syndrome
- When: _____
 When: _____
 When: _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Diverticulitis
When: _____
When: _____ | <input type="checkbox"/> Crohn's Disease
When: _____
When: _____ | <input type="checkbox"/> Ulcerative Colitis
When: _____
When: _____ |
| <input type="checkbox"/> Hepatitis B
When: _____
When: _____ | <input type="checkbox"/> Barrett's Esophagus
When: _____
When: _____ | <input type="checkbox"/> Ulcer Disease
When: _____
When: _____ |
| <input type="checkbox"/> Cirrhosis
When: _____
When: _____ | <input type="checkbox"/> Hepatitis C
When: _____
When: _____ | <input type="checkbox"/> Fatty Liver
When: _____
When: _____ |
| <input type="checkbox"/> Pancreatitis
When: _____
Other: _____ | <input type="checkbox"/> Celiac Disease
When: _____
When: _____ | <input type="checkbox"/> Bowel Obstruction
When: _____
Other: _____ |
| | <input type="checkbox"/> Anemia
When: _____
When: _____ | |

Cardiology

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Coronary Artery Disease
When: _____
When: _____ | <input type="checkbox"/> Congestive Heart Failure
When: _____
When: _____ | <input type="checkbox"/> Heart Attack
When: _____
When: _____ | <input type="checkbox"/> Atrial Fibrillation
When: _____
When: _____ |
| <input type="checkbox"/> Vascular Disease
When: _____
When: _____ | <input type="checkbox"/> High Cholesterol
When: _____
When: _____ | <input type="checkbox"/> Stroke
When: _____
When: _____ | <input type="checkbox"/> Transient Ischemic Attack
When: _____
When: _____ |
| <input type="checkbox"/> Valvular heart disease
When: _____
Other: _____ | <input type="checkbox"/> Pacemaker
When: _____
Other: _____ | <input type="checkbox"/> Coronary Artery Stents
When: _____
When: _____ | <input type="checkbox"/> Essential Hypertension
When: _____
When: _____ |

Pulmonology

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> C.O.P.D.
When: _____
When: _____ | <input type="checkbox"/> Asthma
When: _____
When: _____ | <input type="checkbox"/> Sleep apnea
When: _____
Other: _____ | <input type="checkbox"/> Blood Clots (leg)
When: _____
Other: _____ |
| <input type="checkbox"/> Blood Clots (lung)
When: _____
When: _____ | <input type="checkbox"/> Wheezing
When: _____
When: _____ | | |

Other

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

Drug Use

None

Type	Quantity	Number	Frequency
<input type="checkbox"/> IV or Intranasal drugs			Times / month
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased/At Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause of Death						
Diagnoses						
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Colon cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crohn's disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gallbladder disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcerative colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Review Of Systems

Allergic/Immunologic <input type="radio"/> None HIV exposure persistent infections strong allergic reactions or urticaria	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>	Genitourinary <input type="radio"/> None dark urine decrease in urine flow dysuria frequent urinary infections frequent urination hematuria	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>	Psychiatric <input type="radio"/> None anxiety depression difficulty sleeping hallucinations	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>
Cardiovascular <input type="radio"/> None chest pain irregular heart beat orthopnea palpitations peripheral edema	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>	Hematologic/Lymphatic <input type="radio"/> None bleeding gums or palpable lymph nodes easy bruising prolonged bleeding	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>	Respiratory <input type="radio"/> None asthma cough dyspnea coughing up blood shortness of breath with exercise wheezing	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>
Constitutional <input type="radio"/> None fatigue fever loss of appetite malaise sweats weight gain weight loss	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>	Integumentary <input type="radio"/> None allergies hives itching rashes	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>		
ENMT <input type="radio"/> None difficulty swallowing dizziness ear pain nose bleeds sore throat hearing loss	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>	Musculoskeletal <input type="radio"/> None arthritis back pain gout joint deformity joint pain muscle weakness	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>		
Endocrine <input type="radio"/> None excessive thirst hair loss heat intolerance	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>	Neurological <input type="radio"/> None dizziness fainting frequent headaches migraine numbness or tingling seizures tremors vertigo memory loss	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>		
Eyes <input type="radio"/> None double vision loss of vision photophobia	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>				
Gastrointestinal <input type="radio"/> None abdominal pain abdominal swelling change in bowel habits constipation diarrhea gas heartburn jaundice nausea rectal bleeding stomach cramps vomiting difficulty swallowing	Y N <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/> <input checked="" type="radio"/>				

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