PREMIER
GASTROENTEROLOGY

TERENCE L. ANGTUACO MD ANGELO G. COPPOLA MD BRIAN T. HUGHES MD R. STEVEN JONES MD
DAVID R. MCELREATH DO DHAVAL H. PATEL MD R. PAUL SVOBODA MD

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,

David R. McElreath

RS

ty Small's-Little Rock

Footlights

Supercuts

Premier Gastroenterology. A

Asia Buffet

GNC

Battle St

Cecil's Fine Jewelry

N Shackleford Rd

N Rodney Parham Rd

N Rodney Parham Rd

430

430

Grapevine Wines & Spirits

10 Fitness

Olive Garden

Carriage Cove

Kingspark Rd

Colony West Shopping Center

10915 N Rodney Parham Rd, Little Rock, AR 72212

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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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

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 I
Little Rock, AR 7221
(501) 747-282

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GASTROENTEROLOGY

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: Other:
	Pancreatitis When: Other:	Anemia When:	

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: Other:	Pacemaker When: Other:	Coronary Artery Stents When:	Essential Hypertension When:
Pulmonology	C.O.P.D. When:	Asthma When:	Sleep apnea When: Other:	Blood Clots (leg) When: Other:
	Blood Clots (lung) When:	Wheezing When:		
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

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

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