

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,

10915 N Rodney Parham Rd, Little Rock, AR 72212



Doctor:	
Date:	
Account #	

INSURANCE VERIFICATION FORM

Full Name:			Dat	e of Birth:		
SSN (Social Security Number):		Email	Address:			
Phone:						
Marital Status (circle one):	Single Married	Widowed	Divorced	Sex (circle	e one): M	F
Employer:	Phor	e:	Addres	s:		7.
Doctor Information:						
Referring Physician:		hone:		Address:		
Family Physician:	<u> </u>	Phone:		Address:		
Primary Insurance:		•				
Insurance Company:			Address	S:		
Policy Number:		-	Group Number	•		·
Policy Holder:		Relations	hip:	SSN:		
Date of Birth:	Emplo	yer:			Sex (circle one)	M F
Secondary Insurance:						
Insurance Company:			Address	s:		
Policy Number:						
Policy Holder:						
Date of Birth:			200.0		Sex (circle one)	
WE WILL BE GLAD TO HELP YOU FILE PAYMENT OF INSURANCE BENEFITS.	FOR YOUR INSURANCE BEI	NEFITS; PAYMENT	OF YOUR CHARGES	SHOULD NOT BE DE	EPENDENT UPON	
I understand I will be responsible fo medical information necessary to cla Gastroenterology Associates will ref me at any time by written notice.	aim reimbursement from i	nsurance compar	ies to whom a clair	n has been submitte	ed. I understand Pr	remier
Patient/Guardian:		Date:		Relationshin		



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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

l,	, direct my healthcare provid	ler and medical services providers and pavers to
disclose	and release my health information described below to:	·
Name	Relati	onship:
Contact	nformation:	
Health ir	formation to be disclosed upon the request of the person na	med above – (Check either A or B):
	 Disclose my complete health record (including, but not lim and billing for all conditions) OR Disclose my health record, as above BUT do not disclose the Mental health records Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment Other (please specify): 	ne following (check as appropriate):
Form of	disclosure (unless format is mutually agreed upon between my	provider and designee):
	An electronic record or access through an online portal lard copy	
	norization shall be effective until one calendar year from the ation in writing at any time by notifying your health care pro	
Name of	the Individual Giving this Authorization	Date of Birth
Signatur	of the Individual Giving this Authorization	Date

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



TIEN	TIENT NAME:	DATE OF BIRTH					
	TIENT CONSENT FOR FINANCIAL COMMUNICATIONS UPDATED 5/14/2020**						
1.	1(Patient/Guardian Initials) Financial Agreeme Gastroenterology Associates bill my insurance company for se that are not covered, or covered charges not paid in full includinsurance and/or deductible, or charges not covered by insurareturned checks.	rvices provided to me. I agree to pay for services ling, but not limited to any co-payment, co-					
2.	2 (Patient/Guardian Initials) Cancellations and/your appointment with at least 24 hours' notice before, or fail charged a fee of \$30.00. And, if you do not cancel your appoin show up for a procedure, you will be charged a fee of \$100.00.	to show up for an appointment, you will be tment with 72 hours' notice or more, or fail to					
3.	3(Patient/Guardian Initials) Assignment of Ben Associates any insurance or third-party benefits available for h Premier Gastroenterology Associates has the right to refuse or benefits are not assigned to Premier Gastroenterology Association third-party payments that I receive for services rendered to me	realth care services provided to me. I understand accept assignment of such benefits. If these ites, I agree to forward all health insurance or					
4.	4(Patient/Guardian Initials) Consent to Telephore Premier Gastroenterology Associates, and collection agents, to may owe, I expressly agree and consent that Premier Gastroenterology agree and consent that Premier Gastroenterology Associates or collection agents have obtained transferred from that number, regarding the services rendered contact may include using pre-recorded/artificial voice message applicable.	nterology Associates any or collection agents may mitation of wireless, I have provided or Premier d, or at any phone number forwarded or d, or my related financial obligations. Methods of					
Pat	Patient/Patient Representative Signature :						
	X	Data					



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

Patient Interview Form

First	Name:		and the horizontal and a separate and the second an				The state of the s		A CONTRACTOR OF THE PROPERTY O		

Ema	# W										
		our pref	erred email for co	mmuni	cations						
Race Selec	t one or more										
	White	Chancia	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		Islandel		
Ethn	icity										
	Hispanic or Latino	(1)	Not Hispanic or Latino		Patient declines to specify		Prohibited by state law		Unknown		
Sex		an ann an dùth a bha ann an aighe ann									
	Male		Female		Other		Unknown				
Prefe	erred Language										
tuusii	English	()	Spanish; Castillan		Patient declines to specify	attionemen maatti		Allegarian, I more	ndera mindhirinani kudik di Naré Nakatani na mata mindhirina na kili mtam		
Cont	act Preference								•		
()	Letter		Email		Patient declines to specify	Othe		gg. Stillard vorright af gentjal	r Visit (families für federlichtigt geschießt für mehrlicht erspecieler jese von der verweisent.		
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Name	2		Address	······································				· 	Phone		
Alle	rgies										
	Patient has no k	nown a	llergies		Patient has no kr	iown d	rug allergies	***************************************			
	Adhesive Tape		Codeine Sulfate	(_)	Erythromycin	O	Penicillins	()	Shellfish		

Iv Dye, Iodine Containing	C Latex gloves	Allergy to eggs	Influenza vaccine allergy	
Current Medica	itions			
None		and the control of t		
Name	Dose	Antiphysique grant and his first time and the state of th	How taken?	ann dei de de en en
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<u>Immunizations</u>	**************************************		and a state of the	omet in changes are not the contraction of the cont
None				
Hep A	Hep B	Pneumovax When:	***************************************	Influenza Vaccine
wnen:	_ wnen:	wileit.	VVI(GI) -	Recelved Elsewhere
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Diagnostic Stu	dies/Tests	ising kalang kalang kalang mikes ya ya ya kang katang sanasi mikesi kalanda	**************************************	aria pariante de la compositación de la compositación de la compositación de la compositación de la compositación
O None				and the state of t
Colonoscopy		CT Abdomen/Pelvis	MRI Abdomen/Pelvis	Abdominal Ultrasound
When:	When:			When:
Orbera Balloon Placement				
When:	_	÷		
Previous Proce	edures	tterasionalistikamistaksiriaantilitikuun elemaksi kalikatain elektrisiin talaituun kalikanista.	New Andrewskie (1994) principle of the Control of t	
None				
Gallbladder removed	Appendectomy	Colon resection	Small Bowel Resection	Exploratory Laparoscopy
Gastric Bypass	Gastric Lap Band	Hemorrhoidecton	ny C Hemorrhoid banding	Abdominoplasty
Hysterectomy -	Bilateral Tubal	Mastectomy R Breast	Pacemaker Insertion	Defibrillator Placement
Abdominal Coronary Artery	Ligation (BTL) Abdominal	Heart valve	Cardiac Cath -	O Joint
Bypass Graft (CABG)	aortic aneurysm (AAA) repair	n replacement	with stent placement	Replacement
Back Surgery	Fibromyalgia	Colectomy -	Other:	Other:
		total		
Past or Presen	nt Medical Condit	tions		
C None	fine was the state of the state	adaz, menganakan menendakan pengelakan menganakan menungan menendakan berakan berakan menen	ann princippi an aran a legici di kara kara kara kara kara kara kara kar	isasi isi isasa isas
Gastroenterology/H	lepatology			ndrajiro.
	Colon p		ancer 🗀 Irritable Syndron	
	When:	When:	When:	

	Manual Divertic	•	Disease Ulcerau	When:				
	When:	Barrett Esopha	's () Ulcer E	lsease				
	Hepatiti When: Cirrhosi	When:	Fatty Lives When: Bowel) doch de stermenstere i vo inv				
	When:		When:	decreates abanable or on the				
	Pancrea When: Other:	When:		о фессо обласно при под стег				
Cardiology	Disease	Congestive Heart Failure	Heart Attack When:	Atrial Fibrillation When:				
	When:	When: High Cholesterol When:	Stroke When:	Transient Ischemic Attack When:				
	Valvular heart disease	Pacemaker When:	Coronary Artery Stents	Essential Hypertension				
	When: Other:	Other:	When:					
Pulmonology	C.O.P.D. When:	Asthma When:	Sleep apnea When:	Blood Clots (leg)				
	Blood Clots (lung) When:	Wheezing When:	Other:	Other:				
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)				
	Diabetes Mellitus, Non- Insulin Dependent (Type 2)	Fibrositis / Fibromyalgia When:	Gout When:	When: HIV exposure When:				
	When: HIV infection When:	Hypothyroidism When:	Kidney disease When:	C Kidney stones When:				
	Lung cancer When:	Ovarian Cancer When:	Prostate Cancer When:	Skin Cancer When:				
	Seizures When:	C Tattoos When:	Dementia When:	Alzheimer's disease				
	End-stage renal disease	History of falling When:	Dependence on supplemental oxygen	When: Dependence on wheelchair				
	When:		When:	When:				
Social Histor	٧							
Occupation:	જૈનિકારને તેમ માંગલ છે. ત્રવસ માત્રા સંસ્થા સાથા માંગલ માત્ર માટે ત્રવા માટે હતી. માત્ર કરવાના માટે કરો કરવાના ત્રાંત માત્ર મ	Number of	Children:	and the control of the second				

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9	Clgarettes								**********				***************************************
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Dece	eased/At Age					C)	O _		O	<u> </u>	_	_O
Caus	se of Death	Ta AMA a pháta mhí th sé	is, des silles silled fill file for the sile species and	agh dha ail a dh'a ta an a 2000 da 1920 tha a 192	a can de colon, chan	hána a Záda a a garanna a garan sa kaba	t, as ha sardadh dh'ad a da fadail a		***************	,		to an an array of the state of	
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Celia	ic disease						0		O	0	0	0	0

Colon cancer	O	O	O	O	O	O
Colon polyps	O	0	O	O	O	O
Crohn's disease	O	O	0	O	0	O
Gallbladder disease	O	O	O	0	O	0
Liver disease	O	0	O	O	O	0
Ulcerative colitis	O	0	O	O	0	0

Review Of Systems

Allergic/Immunologic	1	Genitourinary		Psychiatric	1
None	YN	None	YN	None	YN
HIV exposure	COCO	dark urine	00	anxiety	OO
persistent infections	SO	decrease in urine flow	ŌŌ	depression	CO
strong allergic reactions or urticaria	00	dysuria	ÖÖ	difficulty sleeping	00
		frequent urinary infections	77	hallucinations	00
Cardiovascular	1	frequent urination	XX		
	YN	hematuria	XX	Respiratory	1
None	777	nemateria		None	YN
chest pain	XX	11	į	asthma	757
irregular heart beat	$\times \times$	Hematologic/Lymphatic			$\times \times$
orthopnea	XX	None	YN	cough	××
palpitations	QQ	bleeding gums or palpable lymph	00	dyspnea	
peripheral edema	OO	nodes		coughing up blood	QQ
		easy bruising	OO	shortness of breath with exercise	OO
Constitutional	1	prolonged bleeding	00	wheezing	00
None	YN				
fatigue	OC	Integumentary	1		
fever	8 8	None	YN		
loss of appetite	XX	allergies	ററ		
malaise	XX	hives	OO		
sweats	XX	itching	8		
weight gain	XX	rashes	<u></u>		
weight loss	XX				
Weight 1033		Musculoskeletal	1		
CAIREY		None	YN		
ENMT	YN	arthritis			
None difficulty swallowing		back pain	XX		
,	$\times \times$	gout	-XX		
dizziness	XX	joint deformity	-XX		
ear pain	XX	joint delorraty	XX		
nose bleeds	XX	muscle weakness	XX		
sore throat	XX	Huscle weakiess			
hearing loss		Marmalaniani			
		Neurological	V NI		
Endocrine		None	YN		
None	YN	dizziness	XX		
excessive thirst	QQ	fainting	$\times \times$		
hair loss	QQ	frequent headaches	-XX		
heat intolerance	OO	migraine	XX		
		numbness or tingling	××		
Eyes	1	seizures	YY		
None	YN	tremors	QQ		
double vision	QQ	vertigo	QQ		
loss of vision	00	memory loss	OO		
photophobia	OO				
Gastrointestinal					
○ None	ΥN				
abdominal pain	α				
abdominal swelling	$\delta \Delta$				
change in bowel habits	ŎŎ			•	
constipation	77				
diarrhea					
gas	XX				
heartburn	XX				
jaundice	XX				
nausea	\times				
	XX				
rectal bleeding	\times				
stomach cramps	XX				
vomiting	XX				
difficulty swallowing	UU				

Consent to Import Medication History

I cor	nsent to obtaining	g a hi	story of my med	licatio	ns purchased	at pharm	nacies.	
	Yes	(No					
Rer	ninder Prefe	rend	ce	**********	and the state of t			
I wo	uld like to receiv	e pre	ventive care and	follov	v up care rem	inders.		
	Yes		No	(1774(11)); elek e-ellikike)				
Rev	riewed with	**************************************				AN MATTER AND		
	Patient		Parent		Guardian		Not Present	
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Signa	ture	***************************************			Date	ra-Militariariari di Salama Vinanda di Salama di S		