AGIS Alexandria GastroIntestinal Specialists

Dr. Maury K. Morrison & Dr. John L. Gosserand
3311 Prescott Road, Suite 411
Alexandria, LA 71301
Phone: (318) 448-5310 Fax: (318) 448-7110

Notice of Appointment

Dear _____,

You have been referred to our office by _____ .

Your appointment is scheduled on _____ at _____ AM / PM

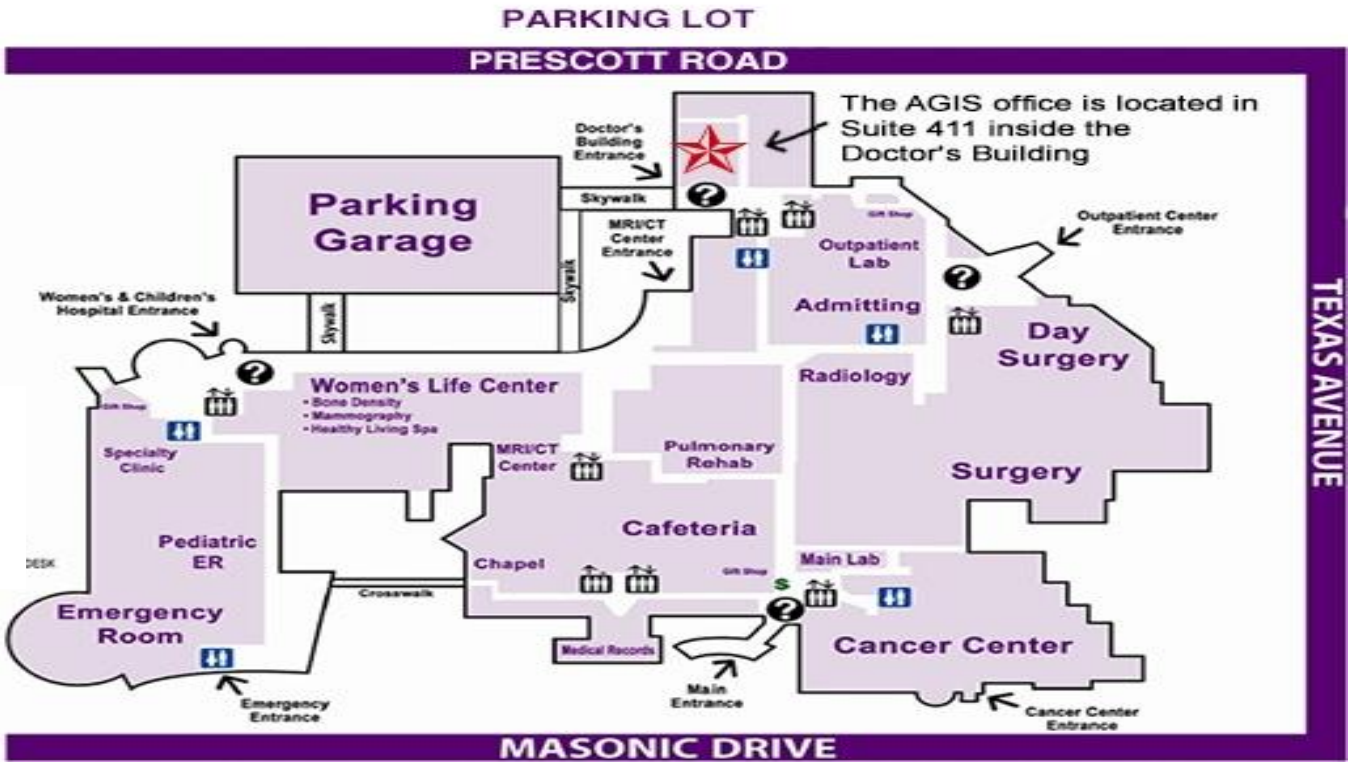
with ◯ Dr. Morrison ◯ Dr. Gosserand ◯ Jill Vidrine, NP

Please bring with you to the appointment:

1. Attached paperwork filled out
2. Insurance Card(s)
3. Photo ID
4. List of Current Medications (DO NOT BRING BOTTLES)

Should you be unable to keep this appointment, please call to cancel or rescheduled within 24 hours.

Thank you and we look forward to seeing you



AGIS Alexandria GastroIntestinal Specialists

Patient Demographic Information

Account #:

Patient Name: _____

Age: _____ Date of Birth: _____ Gender: _____ SSN: _____

Address: _____ Unit/Suite/Apt#: _____

City, State, Zip: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____ Employer Phone: _____

Emergency Contact & Relationship to Patient: _____ Phone:_____

Marital Status:_____ Ethnicity: Hispanic / Non-Hispanic Race: _____

Guarantor/Spouse Name: _____ Date of Birth: _____

Guarantor/Spouse SSN: _____ Phone: _____

Insurance Information

Primary: _____ Policy/Member ID: _____ Group:_____

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____ Sex: Male / Female

Policy Holder SSN: _____ Relationship to Patient: _____

Secondary: _____ Policy/Member ID: _____ Group: _____

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____ Sex: Male / Female

Policy Holder SSN: _____ Relationship to Patient: _____

Primary Care & Referring Physician Information

Are your primary care physician and referring physician the same? Yes ◯ No ◯

Primary Physician: _____ Primary Physician Phone: _____

Referring Physician: _____ Referring Physician Phone: _____

Authorization for Voicemail regarding Health Information

I hereby give permission to leave message(s) on my voicemail concerning my personal health information. **Initials: _____**
I further understand that this permission to communicate my personal health information will remain in effect until I request, in writing, to have this option of communication terminated.

Assignment & Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Alexandria GastroIntestinal Specialists for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance. In the event of default, I agree to pay all costs of collection and responsible attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement is as valid as the original.
AGIS frequently utilizes mid-level practitioners including Advanced Practice Nurses to assist in the delivery of medical care. Mid-level practitioners are under the supervision of a physician and can diagnose, treat, and monitor common acute and chronic diseases. I hereby consent to the services of a mid-level practitioner for my health care needs. I understand that at any time I can refuse to see the mid-level practitioner and request to see a physician.

_____ _____

Signature of Patient of Legal Representative **Date**

AGIS Alexandria GastroIntestinal Specialists

General Consent to Use and Disclosure of Protected Health Information

Name: _____

Account #:_____ Date of Birth: _____

I, _____, understand that **Alexandria GastroIntestinal Specialists** create and maintain medical records that include personal healthcare information, including my health records, symptoms, demographic information, diagnoses, examination, and test results, treatment, and any plans for future care of treatment. This is my "protected health information".
I understand and consent to the use and disclosure of my Health Information by **Alexandria GastroIntestinal Specialists** for the following purposes:

- **MY TREATMENT**- This includes the provision, coordination, or supervision of my healthcare, including the coordination or management of my care and consultation between healthcare professionals related to my treatment or my referral to another healthcare professional.
- **PAYMENT FOR HEATHCARE SERVICES PROVIDED TO ME**: This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my provider or a health plan to obtain or provide compensation for my care.
- **MY PROVIDER'S INTERNAL OPERATIONS**: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities.

I understand and agree that:

- I have the right to review **Alexandria GastroIntestinal Specialists'** *Notice of Privacy Practices*, which provides a detailed description of information uses and disclosures, prior to signing this consent.
- **Alexandria GastroIntestinal Specialists** may change of modify its *Notice of Privacy Practices* at any time and I have the right to obtain a revised copy by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.
- I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my provider is not required to agree to any restrictions that I may request, but if my provider agrees, it will be bound by that restriction.
- Providers at AGIS may require, in the course of my treatment, that I have lab work, radiology, procedures, etc. that will be performed by offices other than AGIS and that they will send me statements from their offices and that AGIS is in no way responsible for their billing practices.

I authorize AGIS to release my medical, including prescriptions, x-rays, orders, doctor excuse, etc. and billing information to the following individuals or entities. This is not a records release, only information requested.

First and Last Name	Relationship to Patient	Phone Number

_____ _____

Signature of Patient or Legal Representative **Date**

AGIS Alexandria GastroIntestinal Specialists

Financial Policy

Name: _____

Account #:_____ Date of Birth:_____

Alexandria GastroIntestinal Specialists (AGIS) has a responsibility to provide quality healthcare services to patients. The following are general financial policies. If you have any issues with payment arrangements, please discuss with a member of our staff.

- Insurance: We will file claims on all visits and procedures, whether they are delivered in our office or the hospital. When we file a claim on your behalf, it is the understanding that the insurance company will pay AGIS directly. You are responsible for payment of all deductibles, co-insurance, copayments, and non-covered services. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.
- Past Due Accounts: Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned over to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance, before being seen by our physicians.
- Out of Network Services: AGIS does not make any guarantees that any laboratory, anesthesiology, or other professional services are in-network providers for your contracted insurance plan. You are responsible for any professional charges in conjunction with the services you receive at the facility whether these services are considered in or out of network with your insurance plan.
- Non-Covered Services: You have scheduled a visit with one of our physicians or nurse practitioners that the physician believes to be relevant to evaluate, monitor, and protect your health. However, Medicare and certain other insurance companies will only pay for services that they determine to be "reasonable and necessary". If it is determined by your insurance company that your visit with a physician at AGIS is not "reasonable and necessary", then they will deny payment for that service. Denial of payment by your insurance company does not mean that you do not need to visit with the physician or nurse practitioner.
- Procedures: An office visit prior to the performance of any procedure is necessary in order to evaluate the patient's general health. In addition, this will endure that the patient is well informed about any recommended procedure and allow the opportunity to obtain informed consent for the procedure. We are required to inform you that your insurance company may not cover certain procedure or office visits and that you are responsible for payment.

Patient Statement- I have been informed of Alexandria GastroIntestinal Specialists' financial policy and agree to its terms. I have been notified that Medicare and other insurances may deny payment for certain services. If my insurance company deems me responsible, I am required to make necessary payments for all services provided.

_____ _____

Signature of Patient or Legal Representative **Date**

Other Information

- Our office hours are 8:30am to 12 Noon and 1:00pm to 5pm, Monday through Thursday; 8:30am to 12 Noon on Friday.
- Dr. Morrison and Dr. Gosserand will see you for hospital stays at Cabrini Hospital if a consult is required.
- Dr. Morrison and Dr. Gosserand perform outpatient procedures at Cabrini Hospital and Central Louisiana Surgical Hospital (CLSH) on Bolton Avenue.
- Should you require refills on prescriptions, all requests are sent to the nurse and may take up to 48 hours to be processed.
- All calls are sent to the nurses' voicemail and will be answered as quickly as possible but may take up to 24 hours.
- I acknowledge that the office of AGIS has notified me of the option to access my medical records through the Patient Portal and HIE (Health Information Exchange). I have chosen to
  - ◯ **Accept** **Email Address: _____**
  - ◯ **Decline**

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

Email—Please check one as your preferred email for communications

○ Personal: _____ ○ Work: _____

Race—Select one or more

○ White ○Black or African African ○Asian ○American Indian or Alaska Native ○Native Hawaiian or Other Pacific Islander

○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

Sex

○Male ○Female ○Other

Preferred Language

○English ○Spanish ○Patient declines to specify

Contact Preference

○Patient Portal ○Other: _____

Allergies

○Patient has no known allergies ○Patient has no known drug allergies

Drug Allergies: ○Penicillin ○Sulfa (Sulfonamides) ○Other: _____

Other Allergies: ○Latex ○Iodine ○Other: _____

Current Medications

○None ○List Attached

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

Immunizations

○None

○ Pneumococcal polysaccharide
When: _____

○Hep B
When: _____

○Hep C
When: _____

○Influenza, seasonal, injectable
When:_____

Diagnostic Studies/Tests

○None

○Upper GI Series
When: _____

○Barium Enema
When: _____

○Abdominal U/S
When: _____

○Abdominal CT
When: _____

○Colonoscopy
When: _____

○EGD
When: _____

○Flex Sigmoidoscopy
When: _____

Past or Present Medical Conditions

○None

○Hypertension
○CAD
○Congestive Heart Failure
○Atrial Fibrillation
○Diabetes
○COPD
○Kidney Failure
○Chronic Kidney Disease
○Anemia
○Elevated Cholesterol
○Asthma
○Osteoporosis
○Lupus
○Stroke
○Arthritis
○Peripheral Vascular Disease
○GERD/Heartburn
○Irritable Bowel Syndrome
○Ulcer Disease
○Diverticular Disease
○Colon Polyps
○Crohns Disease
○Cirrhosis
○Anxiety/Depression
○Venous Thrombosis
○Colon Cancer
○Cancer
○Sleep Apnea
○Ulcerative Colitis
○Hep C
○Pancreatitis
○Hypothyroidism
○Fibromyalgia
○Other: _____

Previous Procedures

○None

○Coronary Bypass
○Heart Valve Replacement
○Pacemaker
○Defibrillator
○Coronary Stent
○Hysterectomy
○Colon Resection
○Stomach Surgery
○Weight Loss Surgery
○Anti Reflux Surgery
○Hemorrhoid Surgery
○Inguinal Hernia Repair
○Umbilical Hernia Repair
○Hip Replacement
○Knee Replacement
○Tonsillectomy
○Aortic Aneurysm Repair
○C-Section
○Appendectomy
○Carotid Endarterectomy
○Cholecystectomy/ Gallbladder
○Other:_____

Family Medical History

○No knowledge of family history

No family history of

○Colon Cancer

○Colon Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Esophagus Cancer	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○

Other: _____

Social History

Marital Status

○Single ○Married ○Divorced ○Widowed

Alcohol

○None

Type: _____ Quantity: _____ Number:_____ Frequency:_____

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:_____

Review of Symptoms CURRENT SYMPTOMS ONLY!!!

CONSTITUTIONAL	Y / N	GASTROINTESTINAL	Y / N	NEUROLOGICAL	Y / N
Fatigue	○ ○	Nausea	○ ○	Dizziness	○ ○
Fever	○ ○	Vomiting	○ ○	Fainting	○ ○
Loss of appetite	○ ○	Vomiting blood	○ ○	Frequent headaches	○ ○
Malaise	○ ○	Heartburn	○ ○	Migraine	○ ○
Sweats	○ ○	Trouble swallowing/food sticking	○ ○	Numbness or tingling	○ ○
Weight gain	○ ○	Painful swallowing	○ ○	Seizures	○ ○
Weight loss	○ ○	Gas/bloating	○ ○	Tremors	○ ○
		Excess belching	○ ○		
INTEGUMENTARY		Abdominal pain or cramps	○ ○	**PSYCHIATRIC**	
Allergies	○ ○	Abdominal swelling/distension	○ ○	Anxiety	○ ○
Itching	○ ○	Change in bowel habits	○ ○	Depression	○ ○
Jaundice	○ ○	Constipation	○ ○	Difficulty sleeping	○ ○
Rash	○ ○	Diarrhea	○ ○	Hallucinations	○ ○
		Excess flatus	○ ○	Nervousness	○ ○
ENMT		Rectal pain	○ ○	Panic attacks	○ ○
Change in voice	○ ○	Bleeding w/ bowel movements	○ ○	Frequent crying	○ ○
Hearing trouble	○ ○	Black/tarry stools	○ ○		
Loss of vision	○ ○	Incontinence of stool	○ ○	**ENDOCRINE**	
Nose bleeding	○ ○	Jaundice	○ ○	Excessive thirst	○ ○
Sore throat	○ ○			Hair loss	○ ○
		GENITOURINARY		Heat intolerance	○ ○
CARDIOVASCULAR		Blood in urine	○ ○		
Ankle swelling	○ ○	Frequent urinary infections	○ ○	**HEMATOLOGIC/LYMPHATIC**	
Chest pain	○ ○	Frequent urination	○ ○	Bleeding gums	○ ○
Irregular heart beat	○ ○	Painful urination	○ ○	Easy bruising	○ ○
Shortness of breath--exertion	○ ○	Urethral discharge/incontinence	○ ○	Enlarged lymph nodes	○ ○
Trouble breathing laying down	○ ○	Frequent urination at night	○ ○	Prolonged bleeding	○ ○
		Decreased urine flow	○ ○		
RESPIRATORY				**ALLERGIC/IMMUNOLOGIC**	
Cough	○ ○	**MUSCULOSKELETAL**		HIV exposure	○ ○
Shortness of breath	○ ○	Back pain	○ ○	Persistent infections	○ ○
Wheezing	○ ○	Joint pain	○ ○	Strong allergic reactions/hives	○ ○
		Muscle weakness	○ ○		

Pharmacy

Name:_____ Address:_____ Phone:_____

Consent to Import Medication History

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.

○Yes ○No

_____

Signature Date