

**University Gastroenterology  
Patient Registration**

PATIENT NUMBER \_\_\_\_\_

**PATIENT INFORMATION**

SOCIAL SECURITY # \_\_\_\_\_ MAILING ADDRESS \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
LAST NAME \_\_\_\_\_ HOME (\_\_\_\_\_) \_\_\_\_\_ WORK (\_\_\_\_\_) \_\_\_\_\_  
SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ CELL (\_\_\_\_\_) \_\_\_\_\_  
MARTIAL STATUS \_\_\_\_\_ FAMILY DOCTOR \_\_\_\_\_  
 MARRIED  SINGLE  DIVORCED  WIDOWED  
NAME OF REFERRING PHYSICIAN \_\_\_\_\_  
EMPLOYMENT STATUS \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
 EMPLOYED  RETIRED  FULL TIME STUDENT  OTHER

**INSURANCE INFORMATION**

PRIMARY INSURANCE \_\_\_\_\_ CARD HOLDER'S NAME \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ DOB \_\_\_\_\_ ID # \_\_\_\_\_  
SECONDARY INSURANCE \_\_\_\_\_ CARD HOLDER'S NAME \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ DOB \_\_\_\_\_ ID # \_\_\_\_\_

**EMERGENCY CONTACT**

RELATIONSHIP \_\_\_\_\_ SEX \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_  
HOME (\_\_\_\_\_) \_\_\_\_\_ WORK (\_\_\_\_\_) \_\_\_\_\_ CELL (\_\_\_\_\_) \_\_\_\_\_

**CONTACT INFORMATION**

PHARMACY \_\_\_\_\_ PHARMACY NUMBER (\_\_\_\_\_) \_\_\_\_\_  
University Gastroenterology will leave **confidential messages** on your answering machine, with a family member or other individual answering the phone when you are not home unless you indicate otherwise. We will safeguard your privacy by limiting the amount of information disclosed. For example, when calling your home we will only leave our name and number and other information necessary to confirm an appointment, or ask you to call back.

**Please contact me as follows:**

HOME TELEPHONE (\_\_\_\_\_) \_\_\_\_\_  
 OK to leave messages with healthcare information  
 Leave message with call back number only.  
 Do NOT leave messages

WORK TELEPHONE (\_\_\_\_\_) \_\_\_\_\_  
 OK to leave messages with healthcare information.  
 Leave message with call back number only.  
 Do NOT leave messages  
 Retired or not working

LIST NAME OF INDIVIDUALS YOU AUTHORIZE US TO SPEAK WITH REGARDING YOUR HEALTHCARE

None  
 Spouse \_\_\_\_\_  
 Child \_\_\_\_\_

Other \_\_\_\_\_  
 Other \_\_\_\_\_

**If we are unable to reach you by any other means, we will send information through the U.S. Postal Service to your home address.**

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I Hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

\_\_\_\_\_  
SIGNATURE (Patient or Parent if Minor)

\_\_\_\_\_  
DATE

## ***University Gastroenterology***

**1930 Alcoa Highway, Suite A-145**

**Knoxville, Tennessee 37920**

**Phone 865-305-6570**

**Fax 865-305-6576**

Please read and sign in space provided below. A copy of this can be provided to you upon request.

We recognize the need for a definite understanding between the patient and the doctor concerning health care and the financial arrangements for this medical care. Our commitment is to provide the very best health care for our patients while recognizing the need to limit services to only those that are necessary for each patient.

Our fees reflect the time spent by the doctor with you, the patient, the specialized nature of the doctor's training, and the individual diagnostic studies performed. Our fees are comparable to other similarly trained specialists in the community.

If you are scheduling a **screening colonoscopy**, or find that you are in need of one in the future, please understand that the pre-certification we get from your insurance company is only a guideline that you can use. If our physician finds that you need a polyp removed during the procedure he will remove it. In this case, this will change your screening to a diagnostic procedure which could **possibly** cause your insurance company to pay less than originally stated. Of course, the fees for care during a specialized procedure or hospitalization may be paid on any mutually agreeable basis. Please contact your insurance company with any additional questions you might have concerning your procedure.

Please let us know if you are having any particular financial problem - you will find us understanding and patient.

**I have read and understand the above.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

# *University Gastroenterology*

## *Payment Policy*

*We are committed to providing you with quality and affordable healthcare. Please read the below and ask any questions you may have, and sign in the space provided.*

**1. Insurance Plans.** We are providers with Medicare, most Aetna plans, Beech Street, Blue Cross Blue Shield of Tennessee, Blue Care, Bowater, Americhoice, Humana, Champus-military only, CIGNA, The Initial Group, PHCS, Preferred Health Partnership (PHP), and United Healthcare. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding our coverage.

**2. Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.

**3. Referrals.** Many patients are now required to obtain referrals or authorizations from their primary care physician (PCP) before receiving treatment from a specialist. It is important that you obtain this from your PCP before coming in for your appointment. Our fax # is 865-305-6576.

**4. Non-Covered Services.** Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit with your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item.

**5. Proof of Insurance.** All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once every year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.

**6. Claim Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any moneys owed after we have received payment from Medicare and/or a secondary policy that you might have.

**7. Non-payment.** If your account is over 90 days past due, you will receive a letter from our billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

**8. HIPAA.** A copy of the UPA Notice of Information Practices has been made available to me. I understand that this notice describes how my health information may be used or disclosed by UPA, physicians and other providers practicing at UPA facilities and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by visiting [www.utmedicalcenter.org](http://www.utmedicalcenter.org).

**I have read and understand the payment policy and agree to abide by its guidelines:**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

A copy of this can be provided to you upon request.

# UNIVERSITY GASTROENTEROLOGY

1930 Alcoa Highway ☞ Suite A-145 ☞ Knoxville, Tennessee 37920

Phone: (865) 305-6570

Fax: (865) 305-6576

Sangeeta (Sandy) Gulati, M.D.

Carlos A. Rollhauser, M.D.

Benjamin P. Dalton, M.D.

Thomas L. Young, M.D.

Shaker Barham, M.D.

## Procedure Financial Clearance Process

University Gastroenterology is required by your insurance company to collect any copay and/or deductible amounts that you have agreed to pay per the contract between you and your insurance company. \_\_\_\_\_ (please initial)

Prior to performing a scheduled procedure University Gastroenterology will verify your insurance eligibility, benefits and deductible. If this information cannot be retrieved while you are in office, you will receive a phone call from our office if you have not met your deductible. UGI will provide you with an estimate from your insurance company stating your financial responsibility based on your insurance benefits. \_\_\_\_\_ (please initial)

The estimated balance due is subject to change pending final processing of the claim by your insurance company according to your contract. UGI will refund any overpayment made by the patient promptly upon final processing of all outstanding claims on the patients account. \_\_\_\_\_ (please initial)

Estimated deductible and copay balances must be paid in full at least one (1) week prior to the date of your scheduled procedure. Failure to pay the estimated balance due at least one (1) week prior to the scheduled procedure will result in the cancellation of your procedure. \_\_\_\_\_ (please initial)

This agreement pertains only to the services provided by University Gastroenterology. You will be billed separately for any services provided to you by the hospital, laboratory, radiology, anesthesia, or for any other services you may receive while at the hospital for your procedure. \_\_\_\_\_ (please initial)

Date \_\_\_\_\_

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Guardian Name if patient is younger than 18 (print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Guardian Signature



# Patient Privacy Questionnaire and Notification

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

**Contact Information:**

I would prefer to be contacted at\*: \_\_\_\_\_ Home # \_\_\_\_\_  
 \_\_\_\_\_ Cell # \_\_\_\_\_  
 \_\_\_\_\_ Work # \_\_\_\_\_  
 \_\_\_\_\_ Other # \_\_\_\_\_

\_\_\_\_\_ May ONLY leave information with me. (If you check here, no other choice should be marked).  
 \_\_\_\_\_ May leave appointment reminders on my answering machine / voicemail.  
 \_\_\_\_\_ May leave lab results on my answering machine / voicemail.  
 \_\_\_\_\_ May leave general questions / information on my answering machine / voicemail.  
 \_\_\_\_\_ May leave a message with a call back number only.

**Please list the name of the individual and relationship of anyone we may give information to:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ May leave appointment reminders with the above listed person  
 \_\_\_\_\_ May leave lab results with the above listed person  
 \_\_\_\_\_ May leave general questions / information with the above listed person  
 \_\_\_\_\_ May discuss billing information with the above listed person  
 \_\_\_\_\_ I prefer that all healthcare messages be given to the above listed person

\*If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL REVIEW OF SYSTEMS**

Please answer all questions by circling your response

**GENERAL:**

Has your appetite been decreased: YES NO  
 Have you been losing weight: YES NO  
 If yes, how much \_\_\_\_\_  
 In what period of time \_\_\_\_\_ Months  
 Any difficulty sleeping: YES NO  
 Loss of interest in things you enjoy: YES NO  
 Do you have fevers: YES NO  
 Do you have shaking chills: YES NO  
 Do you have drenching night sweats: YES NO  
 Weakness, fatigue, easy tiredness: YES NO  
 Lumps, bumps, or swollen glands YES NO

**HEENT:**

Any recent change in vision: YES NO  
 Any ear disease, change in hearing: YES NO  
 Nose, sinus, throat problems: YES NO  
 Any head or neck X-ray treatments: YES NO  
 Any nosebleeds: YES NO

**RESPIRATORY:**

Any shortness of breath with activity: YES NO  
 Any shortness of breath at rest: YES NO  
 Any shortness of breath at night: YES NO  
 Do you have a cough: YES NO  
 Coughing up sputum: YES NO  
 Coughing up blood: YES NO  
 Wheezing or asthma: YES NO  
 Hoarseness: YES NO

**CARDIOVASCULAR:**

Chest pain: YES NO  
 Heart disease: YES NO  
 Palpitations or fluttering heart: YES NO  
 Irregular heart beat: YES NO  
 Ankle adema or swelling YES NO  
 Poor circulation: YES NO  
 Heart murmur: YES NO

**MEDICATIONS: (USE BACK OF PAGE FOR MORE MEDICATIONS)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES: (USE BACK OF PAGE FOR MORE ALLERGIES)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Reviewed: \_\_\_\_\_

**GENITOURINARY:**

Pain or burning with urination: YES NO  
 Blood in the urine: YES NO  
 Increased urinary frequency: YES NO  
 Trouble starting or stopping urine: YES NO  
 Getting up at night to urinate: YES NO  
 Incontinence: YES NO  
 Men: Prostate enlargement YES NO  
 PSA elevation YES NO  
 Impotence YES NO

**MUSCULOSKELETAL:**

Bone pain: YES NO  
 Rheumatoid or osteoarthritis: YES NO  
 Joint swelling: YES NO

**NEUROLOGICAL:**

Headaches-frequent or severe: YES NO  
 Dizziness or fainting: YES NO  
 Have you ever had a seizure: YES NO  
 Any numbness or tingling: YES NO  
 Difficulty walking: YES NO  
 Difficulty with speech/slurred: YES NO  
 Memory loss: YES NO

**HEMATOLOGIC:**

Bleeding problems: YES NO  
 Nose bleeds: YES NO  
 Blood transfusion: YES NO  
 if yes, when? \_\_\_\_\_  
 Easy bruising: YES NO  
 Excessive bleeding with surgery  
 or dental work: YES NO  
 Have you had a blood clot: YES NO  
 Have you had a stroke: YES NO  
 Have you been on blood thinner: YES NO

**INTEGUMENTARY:**

Changes in skin, hair or nails: YES NO  
 Do you have a lot of itching: YES NO  
 Do you have a rash: YES NO

**ENDOCRINE:**

Enlarged thyroid or goiter: YES NO  
 High blood sugar: YES NO  
 Problem with cold or hot weather: YES NO

**FOR WOMEN ONLY**

Breast lumps or mass: YES NO  
 Abnormal mammogram: YES NO  
 Abnormal Pap smears: YES NO  
 Last menstrual period: \_\_\_\_\_  
 Have you ever taken hormones: YES NO  
 Have you taken birth control pills: YES NO  
 Heavy bleeding or clots with period: YES NO