MEDICAL REVIEW OF SYSTEMS
Please answser 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 periood 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)

_____

PATIENT NAME: _____
Date of Birth: _____

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 menstral period:_____		
Have you ever taken hormones:	YES	NO
Have you taken birth control pills:	YES	NO
Heavy bleeding or clots with period:	YES	NO

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
❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED

FAMILY DOCTOR _____

NAME OF REFERRING PHYSICIAN _____

EMPLOYMENT STATUS
❑ EMPLOYED ❑ RETIRED ❑ FULL TIME STUDENT ❑ OTHER EMPLOYER _____

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 a the time of service. This arrangement is part of your contract with you 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.

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

Mark D. Anderson, M.D. John A. Stancher, M.D. Sangeeta (Sandy) Gulati, M.D.
Carlos A. Rollhauser, M.D Ramanujan Samavedy, M.D. Benjamin P. Dalton, M.D.
Thomas L. Young, M.D. Tausha Monday, APRN

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