ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

How do you plan to pay for this visit? Cash/Check_____ Visa/Mastercard_____ Insurance_____

Do you have a Medical Power of Attorney? ☐Yes ☐No **Do you have a Living Will? ☐Yes ☐No**

*****PLEASE PRINT*****

PATIENT_____DATE OF BIRTH_____AGE_____

ADDRESS_____CITY/STATE_____ZIP_____

SOCIAL SECURITY #_____MARITAL STATUS: S / M / D / W GENDER: Male / Female

HOME #_____WORK #_____CELL #_____

YOUR EMAIL ADDRESS FOR **PATIENT PORTAL ACCESS**_____

RACE (circle one): African American Hispanic Caucasian Other: _____REFUSE TO REPORT

ETHINICITY (circle one): Non-Hispanic Hispanic Other: _____ REFUSE TO REPORT

LANGUAGE: English Spanish Sign Language Other: _____

EMPLOYED BY_____OCCUPATION_____

SPOUSE_____EMPLOYED BY_____WK #_____

RESPONSIBLE PARTY (if different from above) _____

ADDRESS_____

EMPLOYED BY_____ PHONE #_____

EMERGENCY CONTACT (other than spouse or parent) _____

REFERRED BY _____

Pharmacy Information
Name of Pharmacy:
Location:
Rx ID:

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

REQUIRED SIGNATURES

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION (ALL INSURANCES):

I request that payment of authorized insurance benefits be made on my behalf to Alexandria Gastroenterology Associates for any services furnished. I authorize any holder of medical information about me to be released to the insurance carrier and its agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary insurance carrier benefits be made on my behalf to Alexandria Gastroenterology Associates. I authorize any holder of medical information about me be released to Medigap/Secondary insurance carrier and its agents to determine benefits to determine benefits payable for related services. I understand that I do not need to provide my Medigap/Secondary insurance carrier with information concerning Medicare claims because my signing of this authorization will allow Medicare payment information to cross-over automatically.

Signature: _____ **Date:** _____

ALL PATIENTS (REQUIRED):

I understand that as a courtesy Alexandria Gastroenterology Associates will bill my insurance carrier for services rendered. I understand that I am financially responsible and agree to all charges for myself and for the members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon. In the event, legal action should become necessary to collect an unpaid balance due. I agree to pay reasonable attorney fees and other such costs as determined by the court.

Signature: _____ **Date:** _____

CONSENT TO OBTAIN EXTERNAL Rx HISTORY:

I_____ whose signature appears below, authorize Alexandria Gastroenterology Associates and its affiliated providers to view my external prescription history via the RxHub services. I understand that prescription history from multiple other unaffiliated medical providers and staff here, and it may include prescriptions back in time for several years.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF HIPAA:

I _____ whose signature appears below, have the right to review the Notice of Privacy Practices prior to signing this consent. **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists, Cardiac and Vascular Services of Cenla and Alexandria Gastroenterology Associates** reserve the right to revise their Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to office manager, 1587 North Bolton Ave., Suite 1100, Alexandria, La 71303.

Signature: _____ **Date** _____

Patient Name_____ DOB_____

HIPAA Release Form for Individuals Involved in Care of Patient:

I, give Dr. Hollier and Kimberly Sills, FNP-C permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payments for health services that I receive from A. G. A.

**[ ] NONE. My medical records are not to be released to anyone.

This consent is valid until such time as I provide A. G. A. written revocation of it.

Dr. Hollier and Kimberly Sills, FNP-C may speak with:

Name: _____

Relationship: _____ **Phone:**

_____

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____ **Phone:**

_____

Name: _____

Relationship: _____ **Phone:**

_____

**** This form is to be filed in the patient's medical record.**

Signature: _____ **Date:** _____

Patient Name: _____ DOB:_____

ROS (each question below needs to be answered):

Circle Y=Yes / N=No	Symptom	
Y / N	**Chest Pain**	While exercising, do you have chest pain?
Y / N	**Palpitations**	Do you feel your heart racing too fast?
Y / N	**Irregular Heart Beat**	Does your heart beat to slow or fast?
Y / N	**Edema**	Do you have swelling in your ankles?
Y / N	**Shortness of Breath**	Are you short of breath when you walk?
Y / N	**Cough**	Do you have a chronic cough?
Y / N	**Leg Cramps**	Do your legs cramp with exercise?
Y / N	**Weight Loss**	Have you lost weight recently?
Y / N	**Fever**	Are you having any fever?
Y / N	**Night Sweats/Chills**	Are you having night sweats or chills?
Y / N	**Fatigue**	Do you feel tired or weak?
Y / N	**Headaches**	Do you have frequent headaches?
Y / N	**Anemia**	Have you ever been anemic?
Y / N	**Bleeding Problems**	Do you have any bleeding problems after surgery or with cuts?
Y / N	**Numbness**	Does any part of your body get numb?
Y / N	**Seizures**	Have you ever had seizures?
Y / N	**Memory Loss**	Do you have any unusual memory loss?
Y / N	**Depression**	Do you feel depressed or sad?
Y / N	**Difficulty Swallowing**	Do you have problems swallowing solids and/or liquids?
Y / N	**Rectal Bleeding**	Are you experiencing any rectal bleeding? If so, is it bright red, maroon, or black?
Y / N	**Abdominal Pain**	Are you experiencing any abdominal pain? Upper, Lower, or Diffuse?
Y / N	**Nausea/Vomiting**	Are you experiencing any nausea and/or vomiting?
Y / N	**Change in Bowel Habits**	Are you experiencing any diarrhea, constipation, or changes in bowel pattern?
Y / N	**Colonoscopy**	Have you ever had a colonoscopy?
Y / N	**Liver Disease**	Do you have any problems with liver disease? Have you ever had Hepatitis A, B, or C?

Patient Name_____ DOB_____

TOBACCO UTILIZATION

<table>
<tr><td colspan="3">□NEVER USED</td></tr>
<tr><td>□FORMER USER</td><td colspan="2">□<1 MONTH □1-3 MONTHS □3-6 MONTHS □6-12 MONTHS □1-5 YEARS □5-10 YEARS □>10YRS</td></tr>
<tr><td rowspan="3">□CURRENT USER</td><td>□DAILY
□SPORADICALLY</td><td>□READY TO QUIT
□ NOT QUITTING</td></tr>
<tr><td colspan="2">FIRST SMOKE IS _____ MINUTES UPON AWAKENING.</td></tr>
<tr><td colspan="2">SMOKES PER DAY:
□<5 □6-10 □11-20
□21-30 □≥31</td></tr>
</table>

ALCOHOL CONSUMPTION

<table>
<tr><td colspan="2">□NONE</td><td colspan="2">□1-2 DAYS PER MONTH</td></tr>
<tr><td colspan="2">□1-2 DAYS PER WEEK</td><td colspan="2">□MOST DAYS</td></tr>
<tr><td colspan="4">AVERAGE DAILY AMOUNT?</td></tr>
<tr><td>□ 1-2 DRINKS</td><td>□3-4 DRINKS</td><td>□5 -6 DRINKS</td><td>□≥6 DRINKS</td></tr>
</table>

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

Joseph D. Hollier, M.D. ● Kimberly Sills, APRN, FNP-BC

NO-SHOW AND CANCELLATION POLICY

Due to a large increase of last-minute cancellations and no shows for office visits and endoscopy procedures, Alexandria Gastroenterology and Associates will instate a no-show or last-minute cancellation fee **Effective January 1, 2023.**

CANCELLATIONS AND NO SHOWS FOR SCHEDULED OFFICE VISITS:

Cancellation of any office visit requires a minimum of 48 hours notice. If any appointment is not cancelled 48 hours prior to your appointment, there will be a $25.00 cancellation fee which must be paid in full prior to rescheduling your next appointment.

If you do not show up for your appointment, there will be a $25.00 no-show fee that must be paid in full prior to rescheduling your next appointment.

CANCELLATIONS AND NO SHOWS FOR ENDOSCOPY PROCEDURES:

Cancellation of a colonoscopy, EGD or other scheduled endoscopy procedure requires a minimum of 72 hours notice. If any scheduled endoscopy procedure is not cancelled in at least 72 hours prior to the procedure, there will be a $75.00 cancellation fee that must be paid prior to scheduling your next office visit OR rescheduling an endoscopy procedure.

If you do not show up for your colonoscopy, EGD or other scheduled endoscopy procedure, there will be a $75.00 no-show fee that must be paid prior to scheduling your next office visit OR rescheduling an endoscopy procedure.

*****NO SHOW AND CANCELLATIONS FEES ARE THE RESPONSIBILITY OF THE PATIENT. INSURANCE DOES NOT COVER NO SHOW AND CANCELLATION FEES AND WILL NOT BE FILED*****

REPEAT OFFENDERS:

Any office visit or endoscopy procedure that is consistently rescheduled or no showed could result in being discharged from our clinic

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____

1587 North Bolton Avenue, Suite 1100 ● Alexandria, LA 71303 ● Ph. 318-473-8188 ● Fax 318-473-8682