.Sumter Gastroenterology

"Your Partners in Digestive Health"

641 W. Wesmark Blvd

Sumter, SC 29150

PH:(803)905-6944 FX:(803)469-3944

Kent Cunningham, M.D. Scott McDuffie, M.D.

Floyd Angus, M.D. April T. Rogers, PA-C

Greg Byrd, APRN Chasity Shadoan, APRN

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip Code: _____

Home Phone: (___)___-____ ☐ Cell Phone: (___)___-____ ☐
(Check Box for Preferred Contact Number)

Social Security No.: _____ Sex: _____ Race: _____

Email: _____

Ethnicity: Hispanic Non-Hispanic Primary Language: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: (___)___-____ Contact Date of Birth: _____

Insurance Information:

Primary Insurance :_____

Policy/ID #: _____Group #: _____

Effective Date: _____Policyholder Name:_____

Policyholder SSN:_____Policyholder DOB:_____

Relationship to Patient:_____Policyholder Employer: _____

Secondary Insurance _____

Policy/ID # #: _____Group #: _____

Effective Date: _____Policyholder Name:_____

Policyholder SSN:_____Policyholder DOB:_____

Relationship to Patient:_____Policyholder Employer: _____

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You may give Sumter Gastroenterology written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you would like to authorize a person to receive your protected health information, please fill out the form below. You are also able to give consent for us to leave detailed information (prescription refills, results of tests, lab results, etc.) on your answering machine, voicemail, or any other party that you designate.

Patient Name: _____ Date of Birth: _____

At my request, I authorize Sumter Gastroenterology to disclose my protected health information to:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

At my request, I authorize Sumter Gastroenterology to disclose my protected health information via the following methods:

☐ Leave a detailed message on my home answering machine (Phone #: _____)

☐ Leave a detailed message on my work voicemail (Phone #: _____)

☐ Leave a detailed message on my cell phone voicemail (Phone #: _____)

☐ Fax detailed medical information (Fax #: _____)

*Authorized Signature: _____ Date: _____

PLEASE COMPLETE IF YOU WISH TO CANCEL THE ABOVE AUTHORIZATION:

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I understand that the cancellation will not affect any action that Sumter Gastroenterology took prior to the receipt of this written notice of cancellation.

Signature Authorizing Cancellation: _____ *Date:* _____

Sumter Gastroenterology, LLC
Patient Financial Policies

If you have medical insurance, we will do our best to help you receive your maximum allowable benefits. In order to do this, we need you to understand our financial policies.

- If we participate with your insurance plan, co-payments and any unmet deductible amounts will be required at the time you register. We will verify your insurance benefits at the time of service.

- Some plans require prior authorization from your primary care provider in order for our physicians to see you and receive payment from your insurance plan. While we make every effort to obtain this prior to the date of service, if we do not have this authorization number, we may need to reschedule your appointment.

- If we do not participate with your insurance plan, we will file your insurance claims, however, you will be responsible for any amounts not paid by insurance. Additionally, we may collect a % of the total amount due prior to your visit.

- If you are scheduled to have a procedure performed, we will conduct a pre-operative benefits check with your primary insurance company to determine as accurately as possible what your patient responsible amount will be after insurance pays. Payment is expected as soon as possible, preferably prior to the procedure being performed.

- If you do not give us 24 hours' notice of an appointment cancellation, you may be subject to a $50 cancellation fee.

- If you do not have insurance or for services not covered by insurance, the practice requires payment of 100% of the total charges unless payment arrangements have been made. Please speak with our Business Office Manager if you have any questions or if you need information regarding our Indigent patient care plans.

- It is our policy to send to the patient three consecutive monthly statements with any balance owed to the practice by the patient. Once all attempts at collections are exhausted, the patient's account is then placed with an outside collection agency with management's approval. After that time, the patient agrees to pay the cost of collection including a reasonable attorney's fee, if this account should be placed in the hands of an attorney for collections.

- We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in making payment arrangements.

PLEASE READ THE ABOVE INFORMATION CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read and understand this policy. I also request that payment of authorized benefits be made to Sumter Gastroenterology, LLC. I authorize them to release medical information to my Insurance plan and its agents any information needed to determine these benefits or the benefits payable to related services.

Signature:_____ Date:_____
(Patient and/or responsible party)

Assignment of Insurance/Release and Assignment:

I hereby assign payment of authorized Medicare benefits and any other medical and/or surgical benefits, to include major medical benefits, to which I am entitled, to be paid either to me or on my behalf to Sumter Gastroenterology, LLC, for any services furnished to me by that provider. I authorize release of medical information needed to determine benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy shall be valid as an original. I understand that I am financially responsible for all balances whether or not paid by insurance. I authorized assignee to release all information necessary to secure payments.

_____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. (A copy is available upon arrival)

Signed_____Date:_____

Relationship (If not signed by patient) _____

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only

If patient/patients' representative refuses to sign acknowledgement, please document date and time the notice was presented to patient/patients' representative and sign below.

Presented on (date and time) _____

By (name and title) _____

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

Email

Please check one as your preferred email for communications

◯ Personal:_____ ◯ Work:_____

Race

Select one or more

◯ White ◯ Black or African American ◯ 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 ◯ Patient declines to specify

Contact Preference

◯ Letter ◯ Email ◯ Patient declines to specify Other:_____

Pharmacy

Name Address Phone

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Adhesive Tape
- ☐ Codeine Sulfate
- ☐ Erythromycin
- ☐ Penicillins
- ☐ Shellfish
- ☐ Iv Dye, Iodine Containing
- ☐ Latex gloves

Current Medications

☐ None

Name | Dose | How taken?

Immunizations

☐ None

- ☐ Flu vaccine When:_____
- ☐ Hep A When:_____
- ☐ Hep B When:_____
- ☐ Pneumovax When:_____
- ☐ TB skin test When:_____

Diagnostic Studies/Tests

☐ None

- ☐ Colonoscopy When:_____
- ☐ EGD When:_____
- ☐ CT Abdomen/Pelvis When:_____
- ☐ MRI Abdomen/Pelvis When:_____
- ☐ ERCP When:_____

Previous Procedures

☐ None

- ☐ Gallbladder removed
- ☐ Appendectomy
- ☐ Colon resection
- ☐ Small Bowel Resection
- ☐ Exploratory Laparoscopy
- ☐ Gastric Bypass
- ☐ Gastric Lap Band
- ☐ Hemorrhoidectomy
- ☐ Hemorrhoid banding
- ☐ Abdominoplasty
- ☐ Hysterectomy Abdominal
- ☐ Bilateral Tubal Ligation (BTL)
- ☐ Mastectomy R Breast
- ☐ Pacemaker Insertion
- ☐ Defibrillator Placement
- ☐ Coronary Artery Bypass Graft (CABG)
- ☐ Abdominal aortic aneurysm (AAA) repair
- ☐ Heart valve replacement
- ☐ Cardiac Cath with stent placement
- ☐ Joint Replacement
- ☐ Back Surgery
- ☐ Fibromyalgia

Other:_____ Other:_____

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

- ☐ Colon polyp history
- ☐ Colon cancer
- ☐ Irritable Bowel Syndrome
- ☐ Diverticulitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Barrett's Esophagus
- ☐ Ulcer Disease
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Fatty Liver
- ☐ Cirrhosis
- ☐ Celiac Disease
- ☐ Bowel Obstruction

Pancreatitis Anemia Other:

Other:

Cardiology

Coronary Artery Disease | Congestive Heart Failure | Heart Attack | High blood pressure

Atrial Fibrillation | Vascular Disease | High Cholesterol | Stroke

Transient Ischemic Attack | Valvular heart disease | Pacemaker | Coronary Artery Stents

Other: | Other:

Pulmonology

C.O.P.D. | Asthma | Sleep apnea | Blood Clots (leg)

Blood Clots (lung) | Wheezing | Other: | Other:

Other

Anxiety disorder | Arthritis | Bipolar disorder | Body piercings

Breast cancer | Current pregnancy | Depression | Diabetes Mellitus, Insulin Dependent (Type 1)

Diabetes Mellitus, Non-Insulin Dependent (Type 2) | Fibrositis / Fibromyalgia | Gout | HIV exposure

HIV infection | Hypothyroidism | Kidney disease | Kidney stones

Lung cancer | Ovarian Cancer | Prostate Cancer | Skin Cancer

Seizures | Tattoos

Social History

Occupation:_____ Number of Children:_____

MaritalStatus

Single | Married | Divorced | Separated | Widowed

Civil Union | Unknown | Other

Alcoho l

None

Occasionally | Daily

Caffeine

None

Occasionally | Daily

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
Cigarettes				
Cigar				
Chewing Tobacco				

Drug Use

○ None

Type	Quantity	Number	Frequency
○ IV or intranasal drugs			Times / month
○ Recreational			Times / month

Exercise

○ None

○ Regular exercise ○ Occasional exercise

Family Medical History

○ No knowledge of family history

No family history of

○ Celiac sprue
○ Colon cancer
○ Colon polyps
○ Crohn's disease
○ Liver disease
○ Stomach cancer
○ Ulcerative Colitis / IBD

	Mother	Father	Sister	Other	Grandmother	Grandfather
Health Status						
Age/Date of Birth						
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○
Disabled	○	○	○	○	○	○
In Remission	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○ ____	○ ____	○	○	○	○
Cause of Death						
Diagnoses						
Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

○ None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Constitutional

○ None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

Eyes

○ None	Y	N
double vision	○	○
loss of vision	○	○
photophobia		○
blurred vision		

ENMT

○ Non		
difficulty sw		
dizziness		
ear pain		
nasal obstru		
nose bleeds		
sore throat		
hearing loss	○	○

Integumentary

○ None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Respiratory

○ None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with activity	○	○
wheezing	○	○

Cardiovascular

○ None	Y	N
chest pain	○	○
Shortness of breath with activity	○	○
irregular heart beat	○	○
difficulty breathing while lying down	○	○
palpitations	○	○
swelling of legs, ankles, or feet	○	○
syncope	○	○

Gastrointestinal

○ None	Y	N
abdominal pain	○	○
stomach cramps	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
black colored stools	○	○
gas	○	○
heartburn	○	○
difficulty swallowing	○	○
nausea	○	○
vomiting	○	○
yellow discoloration of skin, nail beds, or eyes	○	○
rectal bleeding	○	○
stool leakage	○	○

Genitourinary

○ None	Y	N
dark urine	○	○
decrease in urine flow	○	○
pain with urinating	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
frequent urination at night	○	○
urethral discharge or incontinence	○	○
urine leakage	○	○

Musculoskeletal

○ None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	●
joint pain	○	●
muscle weakness	○	○
stiffness	○	○

Neurological

○ None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Endocrine

○ None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Hematologic/Lymphatic

○ None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Psychlatric

○ None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

○ Yes ○ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

◯ Yes ◯ No

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present

Signature

Signature Date