Sumter Gastroenterology

"Your Partners in Digestive Health"

641 W. Wesmark Blvd

Sumter, SC 29150

(803)905-6944 (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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Greg Byrd, APRN April T. Rogers, PA-C

Chasity Shadoan, APRN

Patient Name:_____ Date of Birth: _____

Primary Care Physician: _____ Preferred Pharmacy_____

Marital Status (Circle One): Single Married Separated Divorced Widowed

Do you work (Circle One)? Yes No Retired If yes, where?_____

Please list any medications that you are ***allergic*** to: _____

Family History:

Has anyone in your family ever been diagnosed with the following (Circle all that apply):

Colon Polyps, Cancer of Colon/Stomach/Esophagus/Pancreas, Liver Disease, Crohn's, Ulcerative Colitis

Total number of pregnancies ____ Total number of miscarriages/ stillbirths/ abortions_____

Children: Alive (How many?) ____

Social History:

Are you a present cigarette smoker? Y N Are you a former cigarette smoker? Y N

If yes, number of years smoked? _____ Number of cigarettes per day? _____

If applicable, year quit? _____

Do you currently chew tobacco? Y N Did you formerly chew tobacco? Y N

If yes, number of years? _____ How much? _____ If applicable, year quit? _____

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Do you drink alcohol? Y N If yes, number of years? _____ How much/often? _____

If applicable, date quit? _____

Do you use drugs (i.e. marijuana, cocaine, heroin, etc.)? Y N If yes, number of years? _____

How much? _____ If applicable, date quit? _____

Please list any medications that you are currently taking or bring a list with you. Please include inhaled and over-the-counter medications: _____

_____

_____

_____

_____

_____

_____

Please list any surgery that you have had, in childhood and as an adult:_____

_____

_____

_____

_____

Have you ever had any of the following procedures?

Colonoscopy: Y N If yes, when and where? _____

EGD: Y N If yes, when and where? _____

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	Yes	No	Systems Review	Comments
Cardiovascular			Hypertension	
			Chest Pain	
			Heart Attack	Date:
			CHF	
			Murmur/ MVP/ Antibiotic Required	
			Arrhythmias/ Tachycardia	
			Previous Heart Surgery	☐ Artificial Valve Replacement
			Rheumatic Fever	
			Hematologic	☐Anemia ☐Bleeding ☐Clotting ☐Sickle Cell/ Trait
CNS			Convulsions/ Seizures	
			Stroke	
			Muscular Weakness/ Paralysis	
			Arthritis/ Joint Pain	☐Gout ☐Lupus ☐Back Pain
			Fainting or Dizzy Episodes	
Respiratory			Shortness of Breath	☐ Sleep Apnea
			Wheezing	
			Chronic Cough	
			Current Cold/ URI	
			Emphysema	
			TB	☐ Positive PPD ☐Family Hx
			Asthma	
General			GI Problems: ☐Abdominal Pain ☐Constipation ☐Diarrhea ☐Rectal Bleeding ☐Anemia ☐Indigestion ☐Family Hx of Colon Cancer ☐GERD ☐Nausea ☐Vomiting ☐Choking ☐Dysphagia ☐Hx of Colon Polyps	
			Diabetes	
			Hepatitis (Jaundice)	
			AIDS/ HIV	
			Urinary Disease	☐Calculus ☐Hemodialysis
			Prostate Problems	☐ BPH ☐Prostate CA
			Thyroid Problems	
			Dental	☐Dentures ☐Partial ☐Cracked, Chipped, Broken Teeth
			Cancer/ Chemotherapy	
			Skin Breakdown	
			Mental Condition	
			GYN Problems/ LMP-	☐Menopausal ☐Hysterectomy
			Deaf	
			Hard of Hearing	
			Blind	