Referred By: _____

Primary Care Physician: _____

NEW PATIENT INTAKE FORM

Patient Name: _____ DOB: _____
(First) (Middle) (Last)

Age: _____ Sex/Gender: _____ Preferred Pronoun (he/she/they): _____

Social Security # _____-_____ -_____ Drivers License #:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Address: _____
(Street) (City & State) (Zip Code)

Cell Phone #:_____ Home/Work Phone #_____

Pharmacy Name & Phone #:_____

Patient Email Address: _____

May we discuss test results with a family member/friend? _____ Who? _____

May we leave test results on your voicemail? _____

Please check **all** hospitals that are 'in network' within your insurance provider:

☐ AMITA Health Saint Joseph Hospital ☐ Advocate Illinois Masonic Medical Center ☐ Thorek Memorial Hospital

Our goal at Chicago Gastro is to offer you comprehensive medical care. If you have insurance coverage, we will make our best efforts to coordinate your within the limits of your insurance benefit. *I understand that I am financially responsible for all charges incurred for all treatment, including any co-payment, deductible, or remaining balance amount after payment of possible insurance benefits. I authorize the release of any medical information necessary to process any medical claims. I understand that if I have an HMO, it is my responsibility to obtain all referrals for services rendered with our physicians.*

CANCELLATION AND DELINQUENT ACCOUNT POLICY

In an effort to best serve the schedules of our patients: for office visits canceled/rescheduled less than 24 hours in advance, or failure to keep an appointment, patients will incur a $50 charge. For procedures canceled/rescheduled less than 10 days in advance, or failure to keep a procedure appointment, patients will incur a $150 charge. All accounts not paid within 30 days will be forwarded to a Collections Agency and a 30% premium will be placed on all collections accounts. I have read and understand the financial policy of this medical office and agree to be bound by its terms.

Signature of Patient or Legal Guardian **Printed Name** **Date**

History of Present Illness

Location of Discomfort:_____

Severity:_____
(how severe is the discomfort on a scale of 1-10, where 10 is the worst pain)

Duration: _____
(how long have you had this problem – weeks, months, years)

Modifying factors: _____
(what makes your symptoms better/worse)

Please Circle Any Gastrointestinal Medications you have taken within the past month:

Aspirin containing medications: Excedrin, Aspirin, Alka-Seltzer .....
Arthritis medications: Nsaids, Motrin, Ibuprofen, Advil, Aleve .....
Ulcer medications: Prilosec, Prevacid, Aciphex, Tagamet, Protonix, Nexium .....
Stomach cramp medications: Librax, Levsin, Hyoscyamine, Bentyl NuLev, Zelnorm.....
Nerve pills: Xanax, Valium, Prozac, Zoloft, Paxil .....
Blood thinners: Coumadin, Aspirin, Heparin, etc.....
Anti nausea medications: Phenergan, Zofran, Compazine .....
Laxatives: Correctol, Senokot, Lactulose, Miralax.....
Herbal Products _____ .....
Gastric emptying pills: Reglan, Propulsid.....
Fiber supplements: Metamucil, Fiber-Con, Citrucel, Konsyl.....
Diet pills: Prescription or over-the-counter_____ .....
Cholesterol medications: Questran powder, Cholestid, Welchol .....
Diarrhea medications: Imodium, Lomotil Pepto Bismol.....
Colon medications: Asacol, Pentasa, Prednisone, Imuran, Purinethol, Methotrexate, Remicade

Medications: (Include over the counter and herbal products)

Name	Dose /Frequency	Condition Being Treated

Allergies (medications, foods)

_____

Medical History

Arthritis/Gout …… No Yes
Bleeding Tendency ..... No Yes
Breathing Problems ..... No Yes
Cancer ..... No Yes
Diabetes ..... No Yes
Heart Failure/Heart Attack..... No Yes
HIV ..... No Yes
Hypertension..... No Yes
Seizures..... No Yes
Stress/Anxiety..... No Yes
Stroke ..... No Yes
Venereal Disease..... No Yes

Additional Medical Problems:

_____

_____

_____

Previous Hospitalizations/Surgeries/Serious Injuries:

_____

_____

Social History

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Tobacco Use: ☐ Never ☐ Previously, but quit Current packs/day_____
Caffeine Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Drug Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily Drugs used:_____

Family Medical History

Please list any gastrointestinal problems in your family (parents, siblings, grandparents). Examples include stomach/colon/liver problems; polyps, crohns, ulcerative colitis; breast/ovarian/colon/stomach/ liver cancer/ulcer disease

_____
_____
_____
_____
_____

Have you ever had any of the following studies? (please check):

		Where	**Results**	**Date**
Colonoscopy	☐ Yes ☐ No	_____	_____	_____
Ultrasound of gallbladder	☐ Yes ☐ No	_____	_____	_____
CT of abdomen	☐ Yes ☐ No	_____	_____	_____
Endoscopy (stomach)	☐ Yes ☐ No	_____	_____	_____

Current Symptoms

Gastrointestinal - Upper

Abdominal Pain ..... No Yes
Acid Reflux/GERD ..... No Yes
Black Stool ..... No Yes
Excessive Belching ..... No Yes
Food Sticking ..... No Yes
Heartburn ..... No Yes
Indigestion ..... No Yes
Loss of Appetite ..... No Yes
Nausea/Vomiting ..... No Yes
Painful Swallowing ..... No Yes
Vomiting Blood ..... No Yes
Weight Loss ..... No Yes

Gastrointestinal - Lower

Blood in Stool/Rectal Bleeding ..... No Yes
Bowel Movement Urgency ..... No Yes
Change in Bowel Habits ..... No Yes
Constipation ..... No Yes
Diarrhea ..... No Yes
Fecal Soiling ..... No Yes
Gas/Bloating ..... No Yes
Hemorrhoids ..... No Yes
Painful Bowel Movements ..... No Yes
Rectal Pain ..... No Yes

Ears/Nose/Mouth/Throat

Bad Breath/Taste ..... No Yes
Chronic Sinus/Rhinitis ..... No Yes
Mouth Sores ..... No Yes
Nose Bleeds ..... No Yes
Sore Throat/Voice Change ..... No Yes

Allergies

Aspirin/Pain Medication ..... No Yes
Iodine ..... No Yes
Morphine/Narcotics ..... No Yes
Novocain/Anesthetics ..... No Yes
Penicillin/Antibiotics ..... No Yes
Other drugs_____ ... No Yes
Food allergies_____ No Yes

Hematologic

Anemia ..... No Yes
Past Transfusion ..... No Yes

Cardiovascular

Chest Pain ..... No Yes
Palpitations ..... No Yes
Swelling Feet or Ankles ..... No Yes

Constitutional Symptoms

Fever ..... No Yes
Fatigue ..... No Yes
Headaches ..... No Yes
Recent Weight Change ..... No Yes

CHICAGO GASTRO OFFICE AND FINANCIAL POLICY

If you are covered by an insurance plan, and can provide a valid insurance card, we will bill your insurance company. It is your responsibility to contact your insurance carrier to make sure that the seeking medical provider is contracted with your plan/network.

All patients are responsible for all charges for services received. If the patient responsibility portion of your charges, including charges applied to your deductible and/or coinsurance are not paid in full **within 30 days** following the receipt of your billing statement, we will charge the credit card listed below for the unpaid balance**.** Payment plans are available for large account balances and can be customized to fit your needs; please contact the billing office directly for more information. All account balances not paid within 30 days will be forwarded to a Collections Agency and a 30% premium will be placed on all collections accounts.

Circle One: M/C VISA DISCOVER

Credit Card Number: _____ Expiration Date: _____

Name of card holder: _____ Security Code: _____

Cardholder billing address: _____

Cardholder phone number: _____

If you are *not* covered by one of our accepted insurance plans, you must **pay in full at the time of your service.** Many insurance plans do provide reimbursement for "out-of-network" care. Please contact your insurance company directly as to how to submit a claim.

Cancelation Policy

For office visits cancelled/rescheduled less than 24 business hours in advance or failure to keep an appointment, patients will incur a $50 charge. For procedures cancelled/rescheduled less than 10 days or failure to keep a procedure appointment, patients will incur a $150.00 fee. We will charge that fee to the above credit card.

You herby acknowledge receipt of the medical services, authorize us to bill the above credit card for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in your agreement with the credit card issuer.

Medical Records Policy

There is no charge for medical records transferred from physician to physician. For patients requesting a personal copy of their records, the charges are $1.00 per page. FMLA forms are $25.00 per request. Payment is due before records can be copied and sent/released. All record requests need to be in writing on our medical records release form or a medical records release from provided by another physician.

I have read and understand this financial policy:

Patient Signature: _____ Date: _____

Notice of Privacy Practices
Patient Acknowledgement

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Chicago Gastro LLC is committed to protecting the privacy of your medical information. This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

We may use or disclose your health information in the following situations:

- To provide health care services to you, to get reimbursed for those services, and to operate our business
- To assist law enforcement officially as part of an investigation in which you are the victim of a crime, abuse or domestic violence
- To assist public health agencies in the event of a communicable disease or a defective product or device (for example, food or medication)
- To provide you with appointment reminders or information about other services we offer
- To measure your satisfaction with our services or provide you with information about our efforts to raise funds in support of our mission
- If you otherwise give us permission in the form of a written authorization

Although your heath record is the physical property of Chicago Gastro LLC, the information belongs to you. Your rights include the following:

- To request a restriction on certain uses and disclosures on how we may use your health information
- To receive confidential communications about your health care
- To review and photocopy certain records we maintain containing your health information
- To request amendments to your health information
- To know who has accessed your health information and for what purpose
- To obtain this practice's current Notice of Privacy Practices upon request

We are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain by you
- Abide by the terms of this notice
- Not disclose your health information without your authorization, except for purposes of *treatment*, *payment*, or *health care operations*
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

Chicago Gastro LLC reserves the right to change the terms of its Notices of Privacy Practices, and to make new provisions effective for all protected health information that it maintains.

Chicago Gastro LLC

Acknowledgement Form of Privacy Practices

I hereby acknowledge that I have received a copy of Chicago Gastro LLC's Notice of Privacy Practices.

Name: _____

Date: _____

Signature: _____

Relationship to Patient (if signed by a personal representative of patient):_____

File this Acknowledgement Form in the patient's medical record

CHICAGO GASTRO TELEMEDICINE AGREEMENT

Telemedicine involves the use of electronic communication to enable healthcare providers to treat patients remotely and improve patient care. I understand that I will be engaging with my healthcare provider at Chicago Gastro LLC in a telemedicine consultation. Details of my medical history, examination, procedure results, etc will be discussed over the telephone and/or video conference. I understand that there are potential risks to technology, including interruptions, and potential technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests will not be conducted.

I understand that Chicago Gastro will charge my insurance company for my telemedicine visit. I understand that I am responsible for any annual deductible, co-payment, coinsurance, and charges for non-covered visits. I will pay my patient balance in-full within 30 days of receipt of my bill or I will be sent to Collections with a 30% Premium applied to my patient balance.

I hereby acknowledge that I have read this form and authorize this telemedicine arrangement.

Patient Name (Print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____