



George C. Aragon, MD
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 Ryan C. Wanamaker, MD

Welcome to our New Patient!

Your appointment is scheduled for:

Day / Date:	
Registration Time:	Appointment Time:
Physician: Dr.	

Patients will be rescheduled if arrival time is after Appointment Time above.

	Our main office: 1139 Lexington Ave.
	SouthCoast: 1326 Eisenhower Dr, Bldg 2, First Floor
	Rincon: 5715 Hwy 21 South, Ste A
	Other:

You were referred to our practice by Dr. _____

On the day of your appointment, **please bring the following with you:**

- The attached **forms**
- A list of all **medications** you are currently taking
- A copy of the **insurance card** you would like us to file your insurance and/or co-payment **-or-** the pre-determined cash payment.

We encourage you to visit our website at www.savannahgi.com to learn more about our practice including requesting appointment changes or making payments online. Feel free to call our office at **(912)303-4200** if you should have any questions. Turn by turn driving directions to our office location can also be found on our website.

Patient Information

Name: _____
 First Mid Last

Address: _____
 Street or PO Box City State Zip

Home Phone: () _____ **Mobile:** () _____
 Please circle preferred telephone number that you would prefer us to call

Date of Birth: ____ / ____ / ____ **Sex:** M F **Marital Status:** _____ **Race:** _____ **Ethnicity:** Hispanic Non-Hispanic

Soc Sec #: _____ - _____ - _____ **Language:** _____ **Email:** _____
 (E-Mail is for educational purposes only.)

Referring: _____
 Physician Name Phone #

Employer: _____
 Company Name Address City, State, Zip Phone

Emergency: _____
 Contact Person Relationship Phone

Spouse / Parent and/or Responsible Party Information

Primary Insurance Information

Carrier Name: _____ **Carrier Phone #:** _____
Policy #: _____ **Group #:** _____

Claims Address: _____

Subscriber's Name: _____ **Relationship to Patient:** _____

Subscriber's Employer: _____ **Subscriber Birth Date:** _____

Employer Address: _____ **Emp Phone #:** _____ **Subs. SS#:** _____

Secondary Insurance Information

Carrier Name: _____ **Carrier Phone #:** _____
Policy #: _____ **Group #:** _____

Claims Address: _____

Subscriber's Name: _____ **Relationship to Patient:** _____

Subscriber's Employer: _____ **Subscriber Birth Date:** _____

Employer Address: _____ **Emp Phone #:** _____ **Subs. SS#:** _____

If **MEDICARE** is listed as the **Secondary Insurance**, please check the reason:

- Working age beneficiary / spouse Disabled Beneficiary under age 64 VA (Veteran's Administration)
 End State Renal Disease Worker's Compensation Other:

Authorization to Release Information and Assignment of Benefits

I hereby authorize the release of any information necessary to process my insurance claims. I hereby authorize payment directly to the Physician or representative for any professional services rendered to my dependent or me. I further understand that I am financially responsible for any charges not paid by my insurance company, unless my insurance plan is not one that contracts directly with the Physician and they determine that I am not responsible. Regulations pertaining to medical assignment of benefits apply. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor listed above. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

Patient's Signature: _____ **Date:** _____

Guarantor's Signature: _____ **Date:** _____
 (If other than Patient)

Managed Care mandates that you use in-network physicians, labs, hospitals and services in order to receive in-network payment. In order to help you stay compliant with your insurance requirements:

- A copy will be made of your insurance card each time you visit our facility to assure we have the most recent information. If insurance card is not provided, appointment will be handled as self-pay and \$150 will be collected prior to being seen.
- Please note that if your insurance does have a co-pay requirement, this will be collected prior to seeing the provider. If payment is not made at time of service, a \$25.00 penalty will be added to your account balance.
- Patients will be rescheduled if arrival time is after scheduled appointment.
- Please understand, failure to notify your physician of in-network requirements will result in non-payment or penalty by your insurance company and will result in your being billed for services rendered.
- Please let us know if referral numbers and/or authorization for service requests are required by your plan prior to any services being rendered so that you will not be penalized. We will do what we can to assist you with obtaining insurance numbers, but it is ultimately your responsibility to obtain authorization from your primary care physician.
- This office does not guarantee that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay the charges and pursue reimbursement from the insurance company.
- It is understood that returned checks made payable to this office for insufficient funds, stop payments, or other reasons for non-payment will be assessed a \$25.00 service charge for which I agree to be held responsible.
- If you do not show or cancel within 48 hours of a scheduled procedure a \$100.00 service charge may be added to your account balance.
- In the event that your account is placed with a collection agency, a charge that is equal to 30% of your balance will be added to your account to cover collection costs.
- Please be aware the Center for Digestive & Liver Health and The Endoscopy Center do not participate with the carriers listed below. In order to still be seen by one of our physicians, it will be on a cash basis paid in advance of service.

Amerigroup: (912) 235-4471

Wellcare Medicaid: (912) 233-2112

Please circle your Insurance Company's preferred facility:

The Endoscopy Center - St. Joseph's/Candler Health System - Memorial Health University

Please circle your Insurance Company's preferred laboratory:

MEMORIAL HEALTH

LAB CORP

SMITHKLINE

ST. JOE'S/CANDLER

LAB ONE

QUEST

SOUTHCOAST

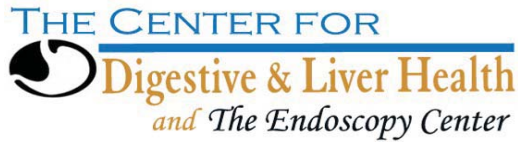
OTHER _____

Pathology Services are performed on-site at the Center for Digestive and Liver Pathology Laboratory.

I have read the above information and understand that I am responsible for notification of my insurance plan mandates.

Signature _____ Date _____

Primary Insurance _____ Date of Birth _____



**Consent for Release of Information
for Medical Treatment, Payment & Health Care Operations**

I, _____, hereby authorize the Center for Digestive and Liver Health or The Endoscopy Center to use, disclose and/or obtain my health information (that specifically identifies me or can reasonably be used to identify me)

- to carry out my medical treatment;
- to receive payment for services rendered on my behalf; and
- to execute general health care operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, the Center for Digestive and Liver Health or The Endoscopy Center can refuse to treat me.

I have been informed by the Center for Digestive and Liver Health or The Endoscopy Center that a notice ("Notice") has been prepared to more fully describe the uses and disclosures made of my individually identifiable health information. I understand my right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time through written notification via certified mail but if I revoke my consent, such revocation will not affect any actions taken prior to receipt of my revocation. Notification to revoke consent must be communicated via certified mail and forwarded to:

Attention –Administrator
1139 Lexington Avenue
Savannah, GA 31404

I understand that the Center for Digestive and Liver Health or The Endoscopy Center has the right to change their privacy practices and I can obtain such changed notice upon request.

I understand my right to choose to request the Center for Digestive and Liver Health or The Endoscopy Center restrict how my individually identifiable health information is used and/or disclosed to carry out my medical treatment, payment for services rendered on my behalf or to execute general health operations. I, also, understand that the Center for Digestive and Liver Health and The Endoscopy Center do not have to agree to such restrictions. However, if such restrictions are agreed to by the Center for Digestive and Liver Health and/or The Endoscopy Center, such restrictions will be adhered to.

Signature of Patient or Patient's Representative

Date

Witness / Relationship

Date

Patient's Social Security #

Patient's Date of Birth

Printed Name of Patient –or- Patient's Representative

Patient Contact Information

Patient Name _____
Social or MRN # _____ Date of Birth: _____
Contact Name _____
Relationship _____
Phone Number 1 _____ Phone Number 2 _____

My home answering machine does not identify me by name, but it is appropriate to leave messages for me there. (Circle) **Yes** **No**

Full Disclosure

I hereby grant permission for *Center for Digestive & Liver Health/The Endoscopy Center* to contact, disclose, and discuss my health information with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") which became effective April 14, 2003.

This means I give permission to Center to call and/or discuss all health information including medical record information, appointments, and billing information with the contact noted above.

Patient's Signature: _____ Date: _____

Appointment ONLY

I hereby grant permission for *Center for Digestive & Liver Health/The Endoscopy Center* to contact, disclose and discuss my health information **relating to appointments only**: requesting, changing, and canceling with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") which became effective April 14, 2003.

This means I give permission to Center to call and/or discuss all information regarding my appointments with the contact name listed above.

Patient's Signature: _____ Date: _____

Insurance and Billing ONLY

I hereby grant permission for *Center for Digestive & Liver Health/The Endoscopy Center* to contact, disclose and discuss my health information **relating insurance and billing issues with the person named above**. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") which became effective April 14, 2003. *This means* I give permission to Center to call and/or discuss all information regarding my financial obligations to the Center with the contact name listed above.

Patient's Signature: _____ Date: _____

Patient Name: _____ Social Security #: _____

Date: _____ Date of Birth: _____

FAMILY HISTORY/SOCIAL HISTORY

Please check if a family member has any of the following:

	Mother	Father	Brothers/Sisters	Children
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you married? _____ How many children do you have? _____

Is your father living? _____ Is your mother living? _____

How many brothers and sisters (siblings) do you have? _____

Present occupation: _____

Do you drink any alcohol? _____ How often? _____

Any history of frequent alcohol use in the past? _____ If yes, when did you quit? _____

Do you smoke? _____ How much? _____

Any history of tobacco use in the past? _____ If yes, when did you quit? _____

MEDICAL/SURGICAL HISTORY

ALLERGIES TO MEDICATIONS:

(NOTE: PLEASE BRING YOUR MEDICATIONS WITH YOU ON THE DAY OF YOUR APPOINTMENT .)

Please provide a list of your medical problems:

Please provide a list of surgeries you have undergone:

Surgery(s) _____

Date(s) _____

Mark Murphy, MD
Edward Rydzak, MD

Steven Carpenter, MD
Charles Duckworth, MD

Ryan Wanamaker, MD
Mark Nyce, MD

Allan Hardy, MD
George Aragon, MD

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW CAREFULLY

Uses and Disclosures

Treatment – Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment – Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services provided, and the medical condition being treated.

Health care options – Your health information may be used as necessary to support day-to-day activities and management of The Center for Digestive and Liver Health and The Endoscopy Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement – Your health information may be disclosed to law enforcement agencies to support government audits and inspectors, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting – Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Type of Facility – Private for profit physician owned facility.

Other uses and disclosures require your authorization. Disclosure of your health information or its uses for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses and Information

Appointment reminders – Your health information may be used by staff to send you appointment reminders.

Information about treatments – Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your private health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

The Center for Digestive and Liver Health and The Endoscopy Center duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulations, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Records Clerk or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Advance Directives

Do you have an advance directive? **Yes** **No** If yes, please provide copy.

It is the policy of The Center for Digestive and Liver Health and The Endoscopy Center to ask each patient about advance directives they may have executed and place a copy in the medical record. However, it will not be enforced as long as the patient is present and being treated. If an emergent event occurs, the patient will be treated and stabilized then transferred to:

- Memorial Health**
- St. Joseph's/Candler Hospital**

where a copy of the advance directives will be sent along with other pertinent patient information.

If you are interested in information regarding Advance Directives you can contact:

Georgia Division of Aging Services, 2 Peachtree Street NW, Suite 9.398, Atlanta, GA 30303-3142 or call the Division's information and Referral Specialist at (404) 657-5319. Copies of the Advance Directives forms and its instructions are available at no cost to you at the following websites:

<http://aging.dhr.georgia.gov/DHR-DAS/GEORGIA%20ADVANCE%20DIRECTIVE%20FORHEALTH%20CARE-07.PDF>

<http://gha.org/publications/public/other/AdvanceDirective.pdf>

Any grievances may be filed in writing at anytime to:

- 1) Attn: Lynne Marini
The Center for Digestive and Liver Health
and The Endoscopy Center
1139 Lexington Avenue
Savannah, GA 31404

Notification of the grievance process includes: whom to contact to file a grievance; that patient will be provided with a written notice of the grievance determination that contains the name of the Center contact person, the steps taken on the patient's behalf to investigate the grievance, the results of the grievance and the grievance completion date.

- 2) Georgia: Health Care Regulation Division Complaint Intake:
2 Peachtree Street NW Suite 31.477
Atlanta, GA 30303-3142
(404) 657-5726 or 5728
1-800-878-6442
- 3) Georgia Composite State Board of Medical Examiners
2 Peachtree Street, NW
10th Floor
Atlanta, GA 30303
(404) 656-3913

or Medicare Recipients may contact

- 4) Office of Medicare Beneficiary Ombudsman at
<http://www.cms.hhs.gov/ombudsman/resources.asp>

Disclosure of Ownership

Please be advised that Drs. Mark Murphy, Edward Rydzak, Charles Duckworth, Steven Carpenter, Mark Nyce and Ryan Wanamaker own an interest in The Endoscopy Center.

The patient is entitled to obtain the services for which you have been referred to The Endoscopy Center at the location of your choice. Alternative sources of the services for which you have been referred to this entity are as follows:

- | | |
|--|---|
| St. Joseph's/Candler
5353 Reynolds Street
Savannah, GA 31405 | Memorial Health
4700 Waters Avenue
Savannah, GA 31404 |
|--|---|

If the patient has further concerns about the care being provided in this licensed ambulatory surgical treatment center, they may express concern to the appropriate representative within the surgery center according to the policy. They may also file a complaint with the Department of Public Health by calling the department of Human Resources Health Care Section at 1-800-878-6442.

I received the previous information verbally and in writing:

Patient Signature _____ **Date** _____ **Time** _____

Patient Name: _____ Social Security #: _____

Date: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Please check if you have experienced any of the following:

General:

- Weight change
- Fevers
- Sweats
- Fatigue
- Do you take any Aspirin, Motrin/Ibuprofen, Aleve, Goody's powders, BC's powders?

Abdomen:

- Abdominal pain
- Rectal bleeding
- Constipation
- Diarrhea
- Difficulty swallowing
- Heartburn
- Nausea/vomiting
- Bloating

Head/Neck:

- Headaches
- Neck stiffness
- Lumps/swelling

Skin:

- Bloating
- Changes in skin

Eyes/Ears/Nose/Throat/Mouth:

- Change in vision
- Discharge from eyes
- Hearing loss
- Ringing in ears
- Nosebleeds
- Sinus congestion
- Sore throat
- Mouth ulcers
- Hoarseness

Musculoskeletal/Neurological:

- Joint/muscle pain
- Back pain
- Loss of memory
- Loss of sensation
- History of stroke

Lungs:

- Shortness of breath
- Cough
- Wheezing
- Do you ever wake up at night short of breath?

Genitourinary

- Frequent urination
- Painful urination
- Incontinence

Heart:

- Chest pain
- Swelling in legs
- Palpitations
- High blood pressure
- Transfusions

Psychiatric

- Depression
- Anxiety

NOTES: _____

PATIENT'S RIGHTS and RESPONSIBILITIES

As a patient, you have the right to:

Confidentiality / Privacy

1. Become informed of rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should patient so desire.
2. Be treated with dignity and receive considerate and respectful care provided in a safe environment, free from all forms of abuse or harassment. (A)
3. Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
4. Confidential treatment of all communications and records pertaining to patient's care and visit at the Center. The patient's written permission shall be obtained before medical records can be made available to anyone not directly concerned with patient's care. (C)
5. Access information contained in your medical records within a reasonable time frame in accordance with state/federal laws and regulations.
6. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in the patient's healthcare.
7. Have a family member or representative notified promptly of admission to the Center.

Ethics

8. Exercise these rights without regard to age, race, disability, sex or cultural, economic, education, or religious background or the source of payment for care given.
9. Be advised of the surgery center's grievance process, should the patient wish to communicate a concern regarding the quality of the care patient receives. Notification of the grievance process includes: whom to contact to file a grievance, and that patient will be provided with a written notice of the grievance determination that contains the name of the Center's contact person, the steps taken on patient's behalf to investigate the grievance, the results of the grievance and the grievance completion date.
10. Expect reasonable safety insofar as the Center's practice and environment are concerned.
11. Know which rules and policies apply to conduct while a patient. Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
12. Know that you can express a complaint regarding your care or any violation of your rights, and that doing so will not adversely affect the quality of care provided.

Information about Treatment

13. Knowledge of the name of the physician and professional staff who have primary responsibility for coordinating the patient's care and the name and professional relationships of other physicians and non-physicians who will participate in care.
14. Receive information from the physician or designee about the illness, course of treatment and prospects for recovery in terms that the patient can understand.
15. Receive as much information about any proposed treatment or procedure as needed in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment. (D)
16. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment. (E)
17. Formulate advance directives regarding patient's healthcare, and have center staff accept for placement on the patient record for use in the event of transfer from the center to an accepting facility (to the extent provided by state laws and regulations).
18. Have personal physician notified promptly of admission to the Center.
19. Change physicians if desired, either within the Center or another physician of the patient's choice.
20. Reasonable responses to any reasonable requests made for service.
21. Leave the Center even against the advice of the attending physician.
22. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care.
23. Be advised if physician/Center proposes to engage in or perform human experimentation affecting the care or treatment. The patient has the right to refuse to participate in such research projects or clinical trials.
24. Be informed by the attending physician or designee of the continuing health care requirements following discharge.

Charges

25. Obtain information before scheduled procedure about payment requirements of the bill, regardless of source of payment.
26. Examine and receive an explanation of the bill regardless of source of payment.
27. A list of these 'Patient's Rights & Responsibilities', which shall be posted within the center so that such rights, may be read by patients.
28. Receive appropriate knowledge regarding absence of malpractice insurance.
29. Receive appropriate information regarding provider credentialing.
30. If eligible for Medicare, to know upon request and in advance of treatment whether a healthcare provider or facility accepts the Medicare assignment rate.

As a patient, you are responsible to:

1. Be respectful of all the health care providers and staff.
2. Smoke in designated areas outside the Center.
3. Be considerate of other patients by helping maintain a quiet atmosphere including cell phones, radios and other distractions.
4. Know your health insurance benefits and be responsible for the prompt fulfillment, including any co-pays or unmet deductibles at time of service, and accept personal responsibility for any charges not covered by your insurance.
5. Know which physician, hospital, laboratory, pathology center, or other service facility your insurance requires you to use.
6. Inform the physician or other medical staff if the treatment, explanations, or expectations are not understood.
7. To provide a responsible adult to transport you home from the facility and remain with you for 24 hours, if required by the provider.
8. Once you and your physician have agreed upon your treatment plan, you must not deviate from the plan. Partial treatment will not be beneficial.
9. If you change your mind or refuse treatment, discuss your reasons with your physician. Accept responsibility for refusing or not following treatment plan.
10. Provide complete and accurate information to the best of your ability about your health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
11. Inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
12. Keep appointments and arrive at the designated time. Or if unable to keep the appointment, to notify the Center at least 24 hours prior to that time.
13. Letting the Center know when your rights are not being respected.