Northern Virginia Gastrointestinal Associates LTD., / Advanced Digestive Care LLC.
3301 Woodburn Road, Suite 107 Annandale VA 22003
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PATIENT REGISTRATION

LastName_____ FirstName_____ SS#_____
Date of
Birth_____ Age_____ Sex:M_____ F_____ Email_____

StreetAddress_____ APT#_____

City_____ State_____ ZipCode_____

HomePhone_____ WorkPhone_____ Ext#_____ Cell_____

Pharmacy:_____ Phone:_____ Marital Status:_____ Employment Status:_____

Emergency Contact Name: _____ Phone:_____ Relationship_____

Please Circle/Race: White Hispanic Black or African American America Indian or Alaska Native
Native Hawaiian or other Pacific Islander Asian Decline Response
Preferred Language: English Spanish Other: _____
Ethnicity: Latino/Hispanic Non Latino/ Non Hispanic

Referring Physician

Name: _____

Phone # _____ Fax# _____

Primary Care Physician

Name: _____

Phone # _____ Fax# _____

Primary Medical Insurance Carrier

Name_____

Insurance ID #_____ Group#_____

Policy Holder_____ Relationship_____

Sex: Male ____ Female_____ Date of Birth_____

Work #_____ Home _____ Cell#_____

Tricare Beneficiaries must provide Sponsor's SS# for claims

Secondary Medical Insurance Carrier

Name_____

Insurance ID# _____ Group#_____

Policy Holder_____ Relationship_____

Sex: Male ____ Female_____ Date of Birth_____

Work #_____ Home _____ Cell#_____

Tricare Beneficiaries must provide Sponsor's SS# for claims

Consent for treatment: By signing this form I consent to treatment by the Medical providers of Northern Virginia Gastrointestinal Associates / Advanced Digestive Care, LLC. I understand that the provider may order diagnostic testing and/or minor surgical procedures I further acknowledge that neither the provider nor the staff can or has made any guarantees or assurances as to the results that are obtained. **Please initial to confirm your agreement with this policy.** _____

I understand that I have certain rights about how my personal information is stored, used, or shared. A complete copy of these rights is available for my review in the office or one will be provided to me should I request it. In addition, I would like healthcare related information to be released to **(please list names below).** Write none if you decline a release of records. This authorization can be revoked at anytime if requested in writing:

_____

_____

Please Initial here to acknowledge this HIPAA Statement _____

Assignment of Benefits: I hereby authorize payment directly to the physician of Northern Virginia Gastrointestinal Associates, LTD/ Advanced Digestive Care, LLC. of any surgical or medical benefits, if any, otherwise payable to me for services. I understand that I am responsible for all non-covered services and I am also responsible for any fees associated with attempting to collect on unpaid balances.

Signature: _____ Date:_____

Northern Virginia Gastrointestinal Associates, LTD. /Advanced Digestive Care, LLC.

My Health History Today's Date:_____

Last Name_____First Name _____Date of Birth _____AGE_____
Referring MD _____Primary MD_____
Reason for your visit_____
Have you ever had a Colonoscopy before? __YES __NO Date _____Location_____
Have you ever had an Endoscopy before? __YES __NO Date _____Location_____

Do you have any allergies to medications? ____YES ____ NO
List Medication Allergies: _____
List all of your Current Medications and Dosage (mg) Please use the other side of this form if additional space is needed.

_____
_____
_____
_____
_____
_____

Dates of Immunization: Hep A _____ Hep B _____Flu _____Pneumonia _____

Please List your Local Pharmacy_____City_____Phone #_____Mail order Pharmacy_____

Date: **Past Surgical History**

_____
_____
_____
_____
_____
_____

Social History

Used Tobacco in the past? Y__N__Quit Date_____
Current Tobacco Use? Y__N__ Packs per Day_____
Drink Alcohol? Y__N__ Glasses Weekly _____
Drink Caffeine? Y__N__ Cups Daily_____
Exercise? Y__N__ How often_____
Travel Outside of US in the last 6 months? Dates:_____
Present Occupation:_____

My Medical History
(Circle ALL that Apply)

Hypertension Jaundice Anemia Liver Disease Diabetes: Type _____ Cancer: Type _____
Bleeding Problem Stroke Heart Disease Asthma Arthritis Blood Transfusion Heart Attack Tuberculosis
Colitis Kidney Stones Colonic Polyps Cardiac Stent Depression Pneumonia Pace Maker HIV/AIDS
Stomach Ulcers Thyroid Disease Heart Murmur Hepatitis: Type___ Chest X-ray Yes ___ No ___
Other: _____ Date of last PPD/TB Test _____Result_____

Circle ALL that Apply to you

Dizziness Hoarseness Belching Fatigue Heartburn Bloating Weakness Nausea Indigestion Constipation Poor Appetite Weight Gain Chest Pain Belly Pain Frequent Cough Weight Loss Difficulty Swallowing Vomiting Blood Coughing Blood Flatulence(gas) Vomiting Rectal Pain Fever/Chills Night Sweats Skin Changes Palpitations Diarrhea Incontinence Hemorrhoids Black Stools Tuberculosis Exposure Change in Bowel Habits Blood/Mucous in stool Shortness of Breath with or without exercise

Family History

Circle the diagnosis and write which family members (grandparents, parents, siblings, spouse, and children) have been diagnosed and include the age at diagnosis for all that apply.

Colon Cancer_____ Colon Polyps_____ Ulcerative Colitis_____

Crohn's_____Stomach Cancer_____Gallbladder Disease_____

Barrett's Esophagus_____ Esophageal Cancer_____Heart Disease_____

Liver Disease_____ Other_____ Diabetes_____

NORTHERN VIRGINIA GASTROINTESTINAL ASSOCIATES, LTD/ ADVANCED DIGESTIVE CARE, LLC

PRACTICE POLICY: General Office Procedures and Financial Procedures

Appointments: When scheduling appointments, it is our intent and wish that you are seen as soon as possible, given the restraints of our mutual schedules. Please be aware that we are mindful of emergencies that may arise or the urgency in which you may need to be seen. To schedule an appointment, please call our office Monday-Thursday, 9-5PM and Friday 9-4PM at 703-876-0437. Failure to cancel an Office Visit will result in a **No Call/ No Show fee of $50.00** and failure to cancel a procedure within 7 business days will result in a **No Call/ No Show Procedure/ Late Cancellation fee of $350.00**, that is not billable to insurance and must be paid prior to rescheduling your Appointment/ Procedure.

Prescriptions: On calling the practice, choose the option for prescription refills. Prescription calls to patients and the pharmacy will be handled within 2 business days (48) hours. You must have had an office visit within one year in order to receive any refills.

Medical Records/Forms: Your written and signed request will be processed within two weeks of our receipt of the request. Requests can be faxed to our office at 703-876-0722, sent by USPS or given in person. The fees associated with Electronic Records is a $20 search fee, plus $0.37 for the first 50 pages and $0.18 cents per page thereafter; for Paper Records, there is $20 search fee, plus $0.50 for the first 50 pages and $0.25 cents per page thereafter. Please keep a personal file of any records that you give us. We do not provide copies of other doctor's records that are in our possession. Each healthcare provider is responsible for providing those records directly to you. Additionally, there is a $50.00 fee for completing disability forms and Insurance applications, a $25.00 fee for FMLA Forms and any dictated letters or requests, etc.

Referrals and Procedure Precertification: Please have necessary referrals and insurance forms with you at the time of your office visit if required by your insurance. This applies to HMO and managed care plans. It is your responsibility to obtain the required paperwork prior to your office visit with your medical provider. If you are unsure if you are required to have a referral, you should call your insurance and/or your primary care doctor. Should your medical provider decide it is necessary to undergo a procedure, our office will make sure pre-certification is complete. **THIS PROCESS IS NOT THE SAME AS GETTING A REFERRAL.** Our office does the best we can to follow each plan's requirements, but due to the number of different insurance plans available today it is impossible for us to know the requirements of every single plan, so it is in the patient's best interest to check eligibility at least 7 days prior to any procedure. If the service being requested by your doctor is medically necessary, but not payable by your insurance, the patient may choose to pay out of pocket and those fees will be provided to the patient in writing before the procedure.

Insurance and Payments: For those patients covered by participating plans, we will file claims to those plans for services we provide to you. Due to significant costs incurred by multiple submissions, our office reserves the right to re-submit medical claims to insurance carriers only **TWO TIMES**; if insurance does not pay after the second attempt and there are not submission errors, the patient will then be liable for the entire balance. Please be advised that we are bound by our contracts with each insurance carrier to collect co-pays, co- insurance, deductibles, and other monies due by the patient to our office at the time of service. In order for our office to ensure care is available to all patients seeking our services, we require that payment of uncovered services is made in full at the time of the visit. Payments can be made in the form of cash, check, MasterCard, Visa, Discover, and American Express. If your check is returned by the bank for any reason there will be a $50 fee assessed to your account that is not covered by insurance. We ask that you adhere to these policies as we are not a lending institution and do not have the resources to extend credit to patients. When payment arrangements must be made, those arrangements must be acceptable to both parties.

Screening VS. Diagnostic Exams: You may believe that you are due for a preventative (screening service), but there may be personal or family history that disallows billing as a preventative service. Please check with your individual plan for your benefits and eligibility at least 7 days prior to your scheduled procedure. The billing office must follow Federal Guidelines when filing medical insurance claims and can help guide you through the process of medical claims and is happy to answer any questions you may have.

Updating Insurance Information: It is the patient's responsibility to provide our office AND the facility with any updated insurance information PRIOR to any treatment. Facilities and offices DO NOT share information. The patient must provide documentation to all parties billing on a patient's behalf. Failure to do so can result in claims being denied and patient being held liable for payment.

Account Balances/Collections: All Payments are due upon receipt of 1st statement. Additionally, any balance that remains unpaid without acceptable arrangements after 90 days will have the potential to be turned over to a collection agency, which can can affect your credit report. If that occurs, the patient will be responsible to pay all balances owed to the collection agency and any fees and interest to Northern Virginia Gastrointestinal Associates LTD. /Advanced Digestive Care LLC as allowed by Virginia Law, **BEFORE** any additional visits will be made with a medical provider.

I have read and understand the above policies.

Signature:_____ Date:_____