Gastrointestinal Associated Specialists
Experienced professionals. Comprehensive capabilities. Unwavering dedication.

PATIENT DATA
FORM MUST BE COMPLETED IN FULL

Name _____ Today's Date _____

Social Security # _____ Date of Birth _____

Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced Gender ❑ Male ❑ Female

Home Address _____
STREET CITY STATE ZIP

Phone Numbers Home _____ Cell _____ Work _____

Primary Phone is ❑ Home ❑ Cell ❑ Work Reminder Call Made to ❑ Home ❑ Cell ❑ Work

Email Address _____ Preferred Contact Method ❑ Phone ❑ Mail ❑ Email

Preferred Language ❑ English ❑ Chinese (Cantonese) ❑ Chinese (Mandarin) ❑ French ❑ German ❑ Italian
❑ Japanese ❑ Portuguese ❑ Russian ❑ Spanish ❑ Declined

Race ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander
❑ White ❑ Other Race ❑Unknown ❑ Declined

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Declined

EMPLOYMENT

Employer _____ Dept. | Title _____

Employer's Address _____
STREET CITY STATE ZIP

Referred to Gastrointestinal Associated Specialists by _____

Address _____
STREET CITY STATE ZIP PHONE

EMERGENCY CONTACT

Spouse, companion, relative, or friend living with you

Name & Relationship _____ Daytime Phone _____

Nearest relative or friend not living with you

Name & Relationship _____ Daytime Phone _____

INSURANCE INFORMATION

Primary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

Secondary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

Tertiary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of GAS and its affiliates. I authorize payment of medical benefits to GAS and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance, and non-covered services.

Patient/Guarantor Signature _____ Date _____

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PERSONAL HISTORY

Today's Date _____

Name _____ Age _____ Date of Birth _____

Referred by _____ Primary Care Physician _____

Other Physicians involved in your healthcare _____

1) Describe the reason(s) for your visit _____

2) List ALL recent medical problems, illnesses (including cancers), hospitalizations and surgeries

_____

_____

3) List the most recent date (and location) any of the following tests or procedures were performed

Labs _____ X-rays _____ CT Scan/MRI _____

Colonoscopy _____ EGD _____ Ultrasound _____

4) **Have you ever had a Pneumococcal (Pneumonia) Vaccine?** ❑ Yes ❑ No

5) Have you ever had a vaccination for Flu, Hepatitis A, Hepatitis B, or Other? ❑ Yes ❑ No

6) Are you currently taking blood thinners such as Coumadin, Plavix, Warfarin, or Xarelto? ❑ Yes ❑ No

7) Are you currently taking aspirin/NSAIDs (Ibuprofen, Advil, Naproxen, or Aleve)? ❑ Yes ❑ No

8) List Current Medications (including herbal) and Dosage

_____

_____

*** Note: You may call your pharmacy and request a med list to be faxed to us at (816) 527-0096*

9) List any allergies _____

_____

10) PREFERRED SERVICES INFORMATION

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____
STREET CITY STATE ZIP

Preferred Laboratory _____

Preferred Radiology _____

11) SOCIAL HISTORY

Provide Details regarding current and/or past use of the following:

Alcohol (beer, wine, liquor) ❑ Yes ❑ No Usage _____

I.V. or Recreational Drugs ❑ Yes ❑ No Usage _____

Tobacco (cigarettes, cigars, chewing tobacco) ❑ Yes ❑ No Usage _____

Smoking Status ❑ Every Day ❑ Some Days ❑ Former ❑ Never ❑ Unknown

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed Children ❑ Yes ❑ No

Occupation _____

12) FAMILY HISTORY (BLOOD RELATIVE)

Colon Cancer	❑ Yes ❑ No	Relation	_____
Colon Polyps	❑ Yes ❑ No	Relation	_____
Crohn's Disease	❑ Yes ❑ No	Relation	_____
Ulcerative Colitis	❑ Yes ❑ No	Relation	_____
Liver Disease	❑ Yes ❑ No	Relation	_____

13) **SYSTEMS REVIEW:** Do you have or have you recently experienced any of the following?

DIGESTIVE SYSTEM	Yes	No
Difficulty in Swallowing	☐	☐
Heartburn/Esophageal Reflux	☐	☐
Nausea/Vomiting	☐	☐
Indigestion	☐	☐
Bloating/Belching/Gaseousness	☐	☐
Abdominal Pain	☐	☐
Gallstones/Gallbladder Disease	☐	☐
Hepatitis or Liver Disease	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Irritable Bowel Syndrome	☐	☐
Gastrointestinal Bleeding	☐	☐
Hemorrhoids	☐	☐
Constipation	☐	☐
Diarrhea/Loose Stools	☐	☐
Change of Bowel Habit	☐	☐
Rectal Bleeding	☐	☐
Black Stool	☐	☐
Mucus in Stool	☐	☐
Unintentional Weight Loss	☐	☐
Anal/Rectal Pain or Itching	☐	☐
Anal Spasms	☐	☐
Anal Fissures	☐	☐

ALLERGY/IMMUNOLOGY		
HIV/AIDS	☐	☐
Blood Transfusion	☐	☐

CARDIOLOGY		
Chest Pain	☐	☐
Pacemaker	☐	☐
History of Heart Attack	☐	☐
Mitral Valve Prolapse or Murmur	☐	☐
Artificial Heart Valve	☐	☐
Hypertension	☐	☐

EARS, EYES, NOSE, THROAT		
Hearing Loss	☐	☐
Ear Pain/Ringing	☐	☐
Mouth Ulcers/Sores	☐	☐
Poor Dentition	☐	☐
Nose Bleeds	☐	☐
Visual Changes	☐	☐

ENDOCRINE	Yes	No
Diabetes	☐	☐
Thyroid Problem	☐	☐
Hormonal Problem	☐	☐

GENITOURINARY		
Are you pregnant?	☐	☐
Date of last period _____		
Recent/Frequent Urinary Tract Infection	☐	☐
Blood in Urine	☐	☐
Burning with Urination	☐	☐
History of Kidney Stones	☐	☐

LYMPHATIC/HEMATOLOGY		
Enlarged Nodes/Swollen Glands	☐	☐
Anemia	☐	☐
Bleeding Problems	☐	☐

MUSCULOSKELETAL SYSTEM		
Lupus, Scleroderma	☐	☐
Joint Pain/Arthritis	☐	☐
Back Pain	☐	☐
Problems Walking	☐	☐

NEUROLOGY		
Seizure Disorder	☐	☐
Headaches	☐	☐
Stroke	☐	☐

PSYCHIATRY		
Depression/Anxiety	☐	☐
Past Evaluation/Treatment	☐	☐

PULMONARY		
Shortness of Breath	☐	☐
Asthma/Wheezing/Cough	☐	☐
COPD	☐	☐

SKIN		
Dermatitis or Rash	☐	☐
Itching	☐	☐
Psoriasis	☐	☐
Jaundice	☐	☐

OTHER _____

_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Name _____ Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT

I, _____, hereby acknowledge that Gastrointestinal Associated Specialists has given me the opportunity to read a detailed notice of their Privacy Practices.

_____ Date _____
Patient/Authorized Representative Signature

If not signed, please provide a reason why the acknowledgement was not obtained.

_____

_____ Date _____
Witness / Staff Signature

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from Gastrointestinal Associated Specialists to speak with the following individuals listed below regarding care of tests results.

Name _____ Phone _____
Relationship _____

Name _____ Phone _____
Relationship _____

Name _____ Phone _____
Relationship _____

Is it OK to leave results or information on your voicemail? ☐ Yes ☐ No

_____ Date _____
Patient/Authorized Representative Signature

CONSENT TO CORRESPOND ELECTRONICALLY

While Gastrointestinal Associated Specialists takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with Gastrointestinal Associated Specialists regarding medical care, the physician and/or his representative has my permission to correspond via that email address.

I give permission for a Gastrointestinal Associated Specialists physician or clinical staff member to email me at _____@_____ regarding medical care.

_____ Date _____
Patient/Authorized Representative Signature

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PATIENT HEALTH RECORD

Gastrointestinal Associated Specialists now provides patients with electronic access to their health records through our Patient Health Record site. This site allows access to Procedure Reports, Lab Results, and Radiology Results safely and securely online. When you request access, a member of our staff will provide the patient/legal guardian with the website address, a username, and a temporary PIN. The first time you log in, you will be prompted to change your password.

Get started today by completing the bottom of this page. We will be happy to answer any questions you may have.

- ☐ Yes, I would like access to the secure Patient Health Record
- ☐ No, I do not want access at this time

_____ Date _____
Patient/Authorized Representative Signature

_____ Date _____
Witness

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RELEASE OF MEDICAL INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name _____ Date of Birth _____

Address _____ City/State Zip _____

The information you may release, subject to this signed release form, is as follows:

- ❑ Complete Records
- ❑ Lab Reports
- ❑ Operative Reports
- ❑ History & Physical
- ❑ Radiology Reports
- ❑ Hospital Records
- ❑ Progress Notes
- ❑ Pathology Reports
- ❑ Medication Record
- ❑ Care Plan
- ❑ Treatment Record
- ❑ Other (see below)

_____

_____

Release my protected health information to the following:

Physician/Person/Facility/Entity _____ Phone/Fax _____

Address _____ City/State Zip _____

Please release as follows:

❑ Fax ❑ Mail ❑ In Person

Patient/Authorized Representative Signature _____ Date _____

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By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name _____ Date of Birth _____

Address _____ City/State Zip _____

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- ❑ Radiology Reports
- ❑ Hospital Records
- ❑ Progress Notes
- ❑ Pathology Reports
- ❑ Medication Record
- ❑ Care Plan
- ❑ Treatment Record
- ❑ Other (see below)

_____

_____

Release my protected health information to the following:

Gastrointestinal Associated Specialists
❑ Gregory A. Schnell, MD ❑ James Walden, MD
1300 NW Briarcliff Pkwy, Ste. 150 Kansas City, MO 64150
PHONE: (816) 527-0031 FAX: (816) 527-0096

_____ Date _____
Patient/Authorized Representative Signature

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FINANCIAL DISCLOSURE STATEMENT

Today's Date _____

Name _____ Age _____ Date of Birth _____

Thank you for choosing Gastrointestinal Associated Specialists. Please read and sign this Financial Disclosure Statement prior to your appointment. Patients who do not pay in full at the time of service must complete the required information and insurance forms before service will be rendered.

You can expect to receive the following bills as a result of your visit:

- **Physician Fee:** Fee to be paid to the physician for performing the service. This bill will be from Gastrointestinal Associated Specialists.
- **Lab Fee:** If a lab test is ordered, a second bill will come from a lab or radiologist.

Some insurance companies require precertification for this service. It is your responsibility to verify your benefits and obtain any necessary precertification prior to your appointment. This is not a guarantee of payment.

Your insurance company will send you an Explanation of Benefits that will explain how your bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand your insurance benefits.

Some insurance plans require you to pay different out-of-pocket amounts based on the location where the service is performed. Deductibles, co-insurance, and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. We will submit primary, secondary, and tertiary claims on your behalf as long as the information needed to process the claim is obtained and verified before your visit. If this information is obtained after your visit or if the information provided is deemed inactive for your dates of service, the patient or guarantor is responsible for the balance.

We accept cash, check, and major credit cards. Gastrointestinal Associated Specialists collects co-payments at the time of service. Additional payment may be required based on your insurance plan.

For an upcoming and/or previous visit, call the office at 816.527.0031 and ask to speak to the financial counselor.

If you are unable to keep your appointment, please reschedule at least 48 hours in advance. A missed appointment will result in a $25 fee. A $30 fee will be incurred for returned checks.

PATIENT'S REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices of Gastrointestinal Associated Specialists and that I may receive multiple bills related to my service as explained above. I authorize payment of medical benefits to Gastrointestinal Associated Specialists and authorize them to release any medical information necessary to process claims. I give Gastrointestinal Associated Specialists permission to apply payments received to balances due at Gastrointestinal Associated Specialists, and understand that payments will be applied to the oldest balance fist. I understand that I am financially responsible for any co-payments, deductibles, co-insurance, and non-covered services as outlined by my health plan.

_____ Date _____
Patient/Authorized Representative Signature

_____ Date _____
Witness