David N. Socoloff, DO
Board Certified Gastroenterologist

NEW PATIENT INFORMATION

Phone 404-282-5600
Fax 404-282-5599

GastroCare Physicians of Georgia

GENERAL INFORMATION

First Name ______________ Middle Initial ________ Last Name ______________

Goes by ______________ Age ________ Marital Status ______________

Date of Birth ______________ Gender ________ SS# ______________

Preferred Language ______________ Race ________ Ethnicity ______________

Street Address ____

City ______________ State ________ Zip: ______________

Work Status ______________ Place of Employment:

E-mail address ____

Cell Phone ______________ Home Phone ________ Work Phone ______________

Preferred Contact (circle one) Home Work Cell

Emergency Contact if we cannot reach you ______________ Phone: ______________

Emergency Contact ______________ Relationship ________

Referred by: ____

Pharmacy Name ______________ Pharmacy Phone Number ______________

Pharmacy Address ____

Mail-In Pharmacy (if applicable) ______________________________

SUBSCRIBER INFORMATION

Self ? ☐ Yes ☐ No

First Name ______________ Last Name ________ DOB ______________

Relationship to Patient ____

INSURANCE INFORMATION (Bring with you to appointment)

Self Pay ☐

Insurance Name(primary): ________ ID# ______________

Group Name: ______________ Group # ______________

Secondary (if applicable): ________ ID# ______________

Group Name: ______________ Group# ______________

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Physicians of Georgia

SOCIAL HISTORY AND HABITS

Name ____________________ Date of birth ____________________ Date ____________

(please provide details regarding current and past use, estimate daily or weekly usage):

	Current use		Past use	
Alcohol (beer, wine, liquor)	☐ Yes	☐ No	☐ Yes	☐ No
Tobacco (cigarettes, cigars, chewing tobacco)	☐ Yes	☐ No	☐ Yes	☐ No
Smokeless(e-cig, vape)	☐ Yes	☐ No	☐ Yes	☐ No

If Yes, check one: ☐ Current everyday smokers ☐ Current some day smoker How many packs per day? ________

IV Drug use / Recreational drug use: Current use ☐ Yes ☐ No Past use ☐ Yes ☐ No

PAST or PRESENT MEDICAL HISTORY

(check if any of the following apply to YOU): ☐ None

☐ Achalasia
☐ Anemia
☐ Auto-Immune Liver Disease
☐ Asthma
☐ Atrial Fibrillation/Arrhythmia
☐ CAD-Coronary Heart Disease
☐ C Diff
☐ Celiac Disease
☐ CHF
☐ Cirrhosis
☐ Colon Polyps
☐ Colon Cancer
☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Other Colitis
☐ COPD
☐ Diabetes
☐ Diverticulitis
☐ Esophageal Cancer
☐ Esophageal Stricture
☐ Fatty Liver Disease
☐ Gastritis
☐ GERD
☐ Hypertension/High Blood Pressure
☐ HIV/AIDS
☐ H Pylori
☐ Hemorrhoids
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lung Disease
☐ Pancreatitis
☐ Pancreatic Insufficiency
☐ Seizures
☐ Sleep Apena
☐ Stroke/TIA
☐ Thyroid Disease
☐ Transplanted Organ

FUNCTIONAL STATUS (Pick One)

☐ No Assistance needed ☐ Walks with Cane ☐ Walks with Walker ☐ Wheelchair Bound ☐ Bed Bound

IMPLANTABLE DEVICES

☐ None ☐ Pacemaker Date__________ Type __________ ☐ Defibrillator Date__________ Type __________

FAMILY MEDICAL HISTORY

Medical Condition	Relation to You
Colon Polyps	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal ☐ Grandparent ☐ Maternal Grandparent
Colon Cancer	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal ☐ Grandparent ☐ Maternal Grandparent
Stomach Cancer	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal ☐ Grandparent ☐ Maternal Grandparent
Esophageal Cancer	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal ☐ Grandparent ☐ Maternal Grandparent
Crohn's Disease	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal ☐ Grandparent ☐ Maternal Grandparent
Ulcerative Colitis	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal ☐ Grandparent ☐ Maternal Grandparent

DO YOU TAKE BLOOD THINNERS OR ASPIRIN?

☐ Yes
☐ No

If there is a possibility of you having an endoscopic procedure (EGD or upper endoscope, colonoscopy, flexible sigmoidoscopy or ERCP) and you are taking a blood thinner, please be sure to discuss this with the doctor.

LIST OF DRUG ALERGIES

☐ No known drug allergies

Medication or other	Reaction

DATE OF LAST COLONOSCOPY

Date ____________________

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MEDICATIONS TAKEN WITH DAILY DOSAGES

☐ List attached ☐ None

Medication Name	Dosage	How Often

PREVIOUS SURGERIES /HOSPITALIZATIONS

☐ List attached ☐ None

Procedure	Date

REVIEW OF SYSTEMS (check symptoms you are experiencing now)

☐ None

GASTROINTESTINAL
☐ Abdominal pain
☐ Abdominal swelling
☐ Changes in bowel habits
☐ Constipation
☐ Diarrhea
☐ Gas
☐ Heartburn
☐ Jaundice
☐ Loss of appetite
☐ Melena
☐ Nausea
☐ Rectal bleeding
☐ Stomach cramps
☐ Vomiting

NEUROLOGIC
☐ Dizziness/fainting
☐ Seizures
☐ Memory loss
☐ Headaches

EYES, EARS, NOSE, THROAT
☐ Difficulty swallowing
☐ Hoarseness
☐ Throat pain

CONSTITUTIONAL
☐ Chills
☐ Fatigue
☐ Fever
☐ Night sweats
☐ Weight loss

MUSCULOSKELETAL
☐ Back pain
☐ Joint pain
☐ Muscle aches
☐ Muscle weakness

CARDIOVASCULAR
☐ Chest pain or discomfort
☐ Palpitations
☐ Peripheral edema

PSYCHIATRIC
☐ Anxiety
☐ Depression
☐ Hallucinations

GENITOURINARY
☐ Dark Urine

RESPIRATORY
☐ Cough
☐ CPAP
☐ Home O2
☐ OSA
☐ Shortness of breath
☐ Wheezing

HEMATOLOGIC
☐ Easy bruising

Date of last flu shot? ____________

Date of last pneumonia shot? ____________

Date of last mammogram? ____________

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PATIENT PRIVACY QUESTIONNAIRE

Phone 404-282-5600
Fax 404-282-5599

GastroCare
Physicians of Georgia

FAMILY MEMBERS / SIGNIFICANT OTHERS

Please list the family members or significant others, if any, whom we may inform about you medical condition and your diagnosis (including treatment, payment, and health care operations) and in case of an emergency.

Name	Relationship	Contact Number

CONDITIONS FOR DISCLOSURE (check or initial one):

______ GastroCare may disclose my personal health information to the individual(s) above only in my presence or;

______ Unless indicated otherwise, GastroCare may disclose my personal health information to the individual(s) above in mypresence as well as when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

2. Please indicate whether you would want to receive calls about your appointment reminders, follow-ups, test results, etc.

☐ YES ☐ NO

3. Can confidential messages (appointment reminders, etc.) be left on your telephone answering machine or voice mail?

☐ YES ☐ NO

PATIENT PORTAL

For your convenience and best practice for protecting patient health information, we strongly encourage thepatient portal set up. Help us eliminate the frustration of phone tag and utilize the patient portal. This is a secureportal where you can review your medical information, send messages, review messages, request refills, and pay your balance. We prefer to use this portal over regular email for security purposes. E-mail you would like us to use? Email___________________________

eRX CONSENT

e-Prescribing has been federally mandated that requires all physicians to prescribe medications electronically beginning in 2011. Prescriptions are sent over the internet to your pharmacy in a safe and secure way through the same technology used by credit card companies. This protects the privacy of your personal information. e-Prescribing software also helps providers see important information like drug interactions and prescription history.

PATIENT CONSENT

I agree that GastroCare Physicians of Georgia may request and use my prescription history from other healthcare providers or pharmacy benefit payors for treatment purposes.

____ ____________________

Patient Signature or Patients Authorized Representative Date

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FINANCIAL & OFFICE POLICY

Phone 404-282-5600
Fax 404-282-5599

GastroCare Physicians of Georgia

All Patients Must Read and Sign The Following Authorization(s) and Consent(s)

COLLECTIONS AND RETURNED CHECK FEE

Should your check be returned by your bank due to insufficient funds or you stop payment on a check or credit card payment, you will be assessed a return payment fee of $35.00. Any unpaid balance that must be turned over to a collection agency will have a 33% collections fee added to the total balance due. You will be required to deal directly with the collection agency to reconcile the balance.

NO SHOW/LATE CANCELLATION FEE

We ask that the patient contact our office 24 hours prior to canceling an appointment. If three (3) no call/no shows occur, it may result in being discharged from our practice due to non-compliance. If you no show for a new patient visit, you may not be able to reschedule. A charge of $50.00 will the responsibility if you do not cancel within 24 hours.

REFERRALS AND VERIFICATION OF INSURANCE

If your insurance requires a referral, it is your responsibility to ensure this has been completed prior to being seen by our providers. It is the responsibility to verify coverage and that we are in-network with your plan. Our billing office can assist you with any verification questions you may have.

NON-PHYSICIAN PRACTITIONERS

Our clinic may utilize Nurse Practitioners and Physician Assistants to better assist with clinic appointments. They work under direct supervision of our physicians at GastroCare Physicians of Georgia, and you may see them in conjunction with our providers for your office visits.

PAYMENTS

is due at the time of service, which may include all deductibles, coinsurance, copays, and past due balances. If your insurance carrier considers any service a non-covered service, or if you are paid directly by your insurance carrier, payment will be expected in full at the time of service. All payment arrangements must be approved by the Practice Administrator. Payment arrangements will only cover the specific charges and dates of service agreed upon. They will not cover additional charges or dates of service. We accept cash, check, money orders, American Express, Discover, MasterCard and VISA.

I have read and understand the Financial and Office Policy for GastroCare Physicians of Georgia.

____

Patient Name

____ ____________________

Patient Signature or Patients Authorized Representative Date

Madison
1680 A Eatonton Road
Madison, GA 30650

David N. Socoloff, DO
Board Certified Gastroenterologist

FINANCIAL & OFFICE POLICY

Phone 404-282-5600
Fax 404-282-5599

GastroCare
Physicians of Georgia

PRIVACY NOTICE

I acknowledge that I have been given a copy of the GastroCare providers Notice of Privacy Practices and/or have been informed where I can receive a copy.

Patient Signature or Patients Authorized Representative ______________________ Date ______________

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by GastroCare Physicians of Georgia deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Patient Signature or Patients Authorized Representative ______________________ Date ______________

AUTHORIZATION AND ASSIGNMENT

I hereby authorize GastroCare Physicians of Georgia to furnish information to Medicare/Insurance carriers concerning my medical conditions, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s)/Medicare to make payment directly to GastroCare Physicians of Georgia for medical diagnostic surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks.

I have completed this form completely and certify that I am the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of all services provided.

I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Patient Name ______________________

Patient Signature or Patients Authorized Representative ______________________ Date ______________

Madison
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POLICIES OF OFFICE (PATIENT COPY)

Phone 404-282-5600
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GastroCare Physicians of Georgia

FACILITY HOURS

Our facility hours are: 9:00 am 4:00 pm Monday Friday 12:00 pm- 1:00pm closed (hours subject to change for meetings, closures, or other circumstances)

If you reach the voice mail during normal work hours, please leave a message for a returned call.

NO SHOW/LATE CANCELLATION FEE

We ask that the patient contact our office 24 hours prior to canceling an appointment. If three (3) no call/no shows occur, it may result in being discharged from our practice due to non-compliance. If you no show for a new patient visit, you may not be able to reschedule. A charge of $50.00 will the responsibility if you do not cancel within 24 hours.

MEDICATION REFILLS

The patient will need to contact our office at least five (5) days prior to running out of medication. If possible, contact your pharmacy and have them send a request to our office (if you choose this option you will not need to contact our office directly.

PRIOR AUTHORIZATION FOR MEDICATION

If your insurance requires a prior authorization, this could take up to two weeks to submit the requested documentation and get an approval. We can try to change your prescription to something on formulary if your request this. You will need to know the alternatives because we do not have this information.

PAYMENTS

is due at the time of service, which may include all deductibles, coinsurance, copays, and past due balances. If your insurance carrier considers any service a non-covered service, or if you are paid directly by your insurance carrier, payment will be expected in full at the time of service. All payment arrangements must be approved by the Practice Administrator. Payment arrangements will only cover the specific charges and dates of service agreed upon. They will not cover additional charges or dates of service. We accept cash, check, money orders, American Express, Discover, MasterCard and VISA.

COLLECTIONS AND RETURN CHECK FEE

Should your check be returned by your bank due to insufficient funds or you stop payment on a check or credit card payment, you will be assessed a return payment fee of $35.00. Any unpaid balance that must be turned over to a collection agency will have a 33% collections fee added to the total balance due. You will be required to deal directly with the collection agency to reconcile the balance.

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Physicians of Georgia

PATIENT PORTAL

Patient Portal- We encourage all patients to utilize the patient portal for better patient communicationand quick access to your health information 24 hours a day. Through your portal, we can send test results, patient education, request refills, pay your bill, send a message or question to your provider's clinical staff, or update demographic information. Let us help you eliminate the burden of phone tag and sign you up on the portal. Speak to a staff member to get signed up today!

TELEHEALTH

After you have been established as a patient with our group, we have the option for acute telehealth services through HIPAA compliant software. This helps minimize the wait time for taking care of your healthcare needs. The video enabled software can be accessed with your smart phone or computer that has camera/video capabilities.

RECALLS AND REMINDERS

-As a courtesy, the medical group utilizes an automated reminder system to help eliminate missing your appointment. If applicable, you will receive an e-mail 5 days out, a phone call 3 days out and last will be a text 2 days out. Please confirm the text or other method so staff do not have to continue to call. You have the option to opt out. Recalls are set up to help remind you about when you need another procedure, labs, etc. We call and then will also send a portal message or letter by mail.

MEDICAL RECORDS REQUEST AND FEES

Upon request, we will forward medical records to another provider for no cost to you or the provider. If you request copies of your records, we can upload them to your patient portal. Copying costs for records in paper form may be subject to Georgia Retrieval Rates.

HIPAA PRIVACY POLICY AND PATIENT RIGHT

- can be found on our website as well as through your patient portal. You can also request a copy from the from a staff of GastroCare Physicians of Georgia.

NO CELL PHONE VIDEO OR VOICE RECORDING IS ALLOW IN THE FACILITES.

Due to HIPAA privacy and patients' rights, phones cannot be used while in the clinic or procedure area.

LANGUAGE SERVICES

Language Services - (pending)

This patient copy of our policies is for guidance only. Our office policies are subject to updates and you should not consider this copy as the most recent policies for GastroCare Physicians of Georgia.

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NOTICE OF PRIVACY PRACTICES

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GastroCare Physicians of Georgia

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) GastroCare Physician of Georgia to maintain the privacy of your health information, inform you of its legal duties and privacy practices with respect to your health information through this notice of Privacy Practices, notify you if there is a breach involving your protected health information, agree to restrict disclosure of your health information to your health plan if you pay out-of- pocket in full for health care services, and abide by the terms of this Notice currently in effect

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to durable medical equipment companies who are helping with your care. Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to access the care and outcomes of your case and others like it
.
Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required By Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, and organ donation agencies.

Serious Threat to Health Or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.
In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the number listed (under "Contact Person") to obtain the appropriate for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and on our Web site. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the number listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the number listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact the Privacy Officer or the HIPAA Compliance Officer 404-282-5600

Effective date September 1, 2013.

Revised 3/20/2003, 3/7/2006, 3/22/2007, 10/30/2012, 9/1/2013, 8/1/2015, 4/2/2020,1/15/24