LAFAYETTE
Gastroenterology
A UNITY HEALTHCARE PARTNER

**5 Executive Drive, Suite B-1**
**Lafayette, IN 47905**
**PH: 765.807.0531**
**FX: 765.807.0534**
***www.lafayettegastro.com***

# PATIENT INFORMATION

LAST NAME:________________________________ FIRST NAME:________________________________ M.I.:__________________________

ADDRESS:__________________________________ CITY:______________________________________ STATE:______ZIP:_______________

DOB:________________________SS#:___________________________ D.L.#____________________________

EMPLOYER:___________________________________________________________________________________________________

MARITAL STATUS: □ MARRIED □ SINGLE □ DIVORCED □ WIDOWED Sex: (Circle) M F Gender Identity: (Circle) M F Both Neither

HOME PHONE: (_____)______________________ WORK PHONE: (_____)________________________ CELL: (_____)_____________________

EMAIL ADDRESS:______________________________________________________________________________________________

EMERGENCY CONTACT:____________________________________________________ PHONE: (_____)________________________________

RACE: □ WHITE □AMERICAN INDIAN OR ALASKA NATIVE □ ASIAN □ BLACK OR AFRICAN AMERICAN
□ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER □ OTHER____________________

LANGUAGE: □ ENGLISH □ SPANISH □ OTHER______________ ETHNICITY: □ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO

PLEASE ENROLL IN OUR PATIENT PORTAL (FOLLOW MY HEALTH). AN INVITE WILL BE SENT TO YOUR EMAIL. THIS IS A VERY IMPORTANT SERVICE, AS NOTIFICATION OF YOUR TEST RESULTS ARE DONE THROUGH THE PATIENT PORTAL. YOU CAN ALSO REQUEST FOLLOW UP APPOINTMENTS.

## *INSURANCE INFORMATION*

PRIMARY INSURANCE:__________________________________ Member/ID #:_____________________________ Group #:_________________

Policyholder's Name:_______________________________ **SSN#**:____________________ **DOB:**_______________Home Phone:________________

Policyholder's Address:_____________________________________________________________________________________
Street City State Zip

Employer:___________________________________________________________________________________________________
Address City State Zip Phone

SECONDARY INSURANCE:______________________________ Member/ID #:_______________________________ Group #:_________________

Policyholder's Name:_______________________________________ Policyholder's Home Phone:______________________________________

Policyholder's Address:_____________________________________________________________DOB:_____________SSN#__________________
Street City State Zip

Employer:___________________________________________________________________________________________________
Address City State Zip Phone

Reason for Visit:__________________________________________________Referral from friend? Name:_________________________________
Referring Physician:_______________________________________________Primary Care Physician:____________________________________
**Pharmacy:**_______________________Street:______________________________City:_________________ Tel. #:_______________________

***FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS, I HEREBY AUTHORIZE THE FOLLOWING:***

1. *Release of any information to obtain medical examination, treatment, referral to another physician, and/or payment (assignment of benefits to be valid until revoked by me in writing.)*
2. *Direct payment of benefits to LAFAYETTE GASTROENTEROLOGY/RAVISH J. MAHAJAN, M.D.*
3. *Photocopies of this form to be as valid as the original.*
4. *A copy of the HIPPA policy is available at www.LafayetteGastro.com or in the office. I will abide by office policies on the website.*
5. *I will notify the office of any changes in my contact information immediately.*
6. ***I am aware that co-payments and deductibles are due at the time of the visit.***
7. *I UNDERSTAND THAT HAVING INSURANCE COVERAGE DOES NOT RELEASE ME OF THIS LIABILITY.*
8. *I hereby consent to Lafayette Gastroenterology, Dr. Ravish J. Mahajan, and its employees, staff, agents, or representatives to treat me for my condition(s). No guarantees of cure have been given, either explicit or implicit.*
9. *The undersigned agrees, that, in the event this account is turned over for collection to a third party, he/she will be responsible for the costs of collection which include, but are not limited to, reasonable attorney's fees, court costs and pre-judgment interest at the statutory rate.*
10. *I give consent to Dr. Mahajan to obtain records from my other physicians and pharmacies.*
11. *If I do not give 3 business days' notice to cancel, I agree to pay $50 cancellation fee.*
12. *I am aware that I will not be receiving any reminder calls for my appointment, and office policies on website will be periodically updated.*

***SIGNATURE OF PATIENT/GUARDIAN:***_______________________________________ ***DATE:***________________

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## Unity Healthcare
## Notice of Privacy Practices for Protected Health Information
## Acknowledgement of Receipt of Notice of Privacy Practices

I am aware that a paper copy is available at the office upon request and understand that my protected health information may be used by the Practice as described in the notice. (The updated form is available on our website at www.lafayettegastro.com.)

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TELEPHONE CONTACTS: I authorize Unity Healthcare, LLC and its affiliates and agents to contact me at the phone numbers I have provided (whether such is a cell phone or a land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me. If a machine or voice mail is reached I understand a message may be left for me. (If you are receiving treatment from multiple Unity Healthcare providers, it may result in multiple calls.)

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# UNITY HEALTHCARE, LLC
## HIPAA RELEASE OF INFORMATION

Name: ____________________________________________ DOB___/___/_____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

**Please list individuals (other than providers) we may speak with regarding your care:**

| Name: | Relationship: |
| --- | --- |
| 1.______________________ | ______________________ |
| 2.______________________ | ______________________ |
| 3.______________________ | ______________________ |

Email address: ____________________________________________

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

**Patient Signature:**____________________________________ **Date**___/___/_____

Name:____________________________________________DOB:______________

**OVER**

# PATIENT HISTORY FORM

| Past Medical History | Yes | No | Surgeries | Yes | No |
|---|---|---|---|---|---|
| Diabetes ....................................> | ☐ | ☐ | Partial hysterectomy .............................> | ☐ | ☐ |
| CAD, MI (heart disease) | ☐ | ☐ | Complete hysterectomy | ☐ | ☐ |
| COPD, lung disease......................> | ☐ | ☐ | Gall bladder .......................................> | ☐ | ☐ |
| Kidney failure | ☐ | ☐ | Appendix | ☐ | ☐ |
| Hypertension (high BP)................> | ☐ | ☐ | Cesarean section ..................................> | ☐ | ☐ |
| High cholesterol | ☐ | ☐ | Removal of adhesions | ☐ | ☐ |
| Cancer ____________________ .....> | ☐ | ☐ | Bladder tack ........................................> | ☐ | ☐ |
| Psychiatric illness | ☐ | ☐ | Inguinal hernia (groin) | ☐ | ☐ |
| Peptic ulcer..................................> | ☐ | ☐ | CABG (cardiac bypass) ........................> | ☐ | ☐ |
| Colon polyp | ☐ | ☐ | Tonsils/Adenoids | ☐ | ☐ |
| Colon cancer...............................> | ☐ | ☐ | Gastric bypass......................................> | ☐ | ☐ |
| Irritable bowel syndrome | ☐ | ☐ | Colon resection (removal/surgery) | ☐ | ☐ |

List other Medical history: List other surgeries:

| Family History | Relation | Yes | No | | Relation | Yes | No |
|---|---|---|---|---|---|---|---|
| Viral hepatitis | __________ | ☐ | ☐ | Crohn's Disease | __________ | ☐ | ☐ |
| Cirrhosis of liver | __________ | ☐ | ☐ | Ulcerative colitis | __________ | ☐ | ☐ |
| Liver cancer | __________ | ☐ | ☐ | Colon Cancer | __________ | ☐ | ☐ |
| Peptic Ulcer | __________ | ☐ | ☐ | Other gastro cancer | __________ | ☐ | ☐ |
| Pancreatitis | __________ | ☐ | ☐ | Breast cancer | __________ | ☐ | ☐ |
| Heart attack/disease | __________ | ☐ | ☐ | Ovarian cancer | __________ | ☐ | ☐ |
| Gallbladder disease | __________ | ☐ | ☐ | Irritable bowel syndrome | __________ | ☐ | ☐ |

Other relevant family history:

| Social History | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|
| Tobacco | Currently? | ☐ | ☐ | Alcohol use: ______________ | ☐ | ☐ |
| | Quit date ______________ | | | Oz. per week ________ Quit date: ________ | | |
| | Packs per day ______________ | | | Alcohol or drub rehabilitation | ☐ | ☐ |
| | Total # years ______________ | | | Date: ______________ | | |
| Diet history | Low fat | ☐ | ☐ | | | |
| | Diabetic | ☐ | ☐ | Last Menstrual Period ______________ | | |
| | Salt restricted | ☐ | ☐ | Are you pregnant? ______________ | ☐ | ☐ |

Medications: (List name, dosage, directions) PLEASE BRING ALL OF YOUR MEDICATION BOTTLES FOR EVERY APPOINTMENT

Occupation:

Previous upper endoscopy: Yes / No / Date:

Previous colonoscopy: Yes / No / Date:

Problems with sedation: Yes / No / Date:

Findings on endoscopy:

| | | |
|---|---|---|
| History of endocarditis | ☐ Yes | ☐ No |
| Prosthetic heart valve | ☐ Yes | ☐ No |
| Recent vascular graft (<1yr) | ☐ Yes | ☐ No |
| Recent joint replacement (<1yr) | ☐ Yes | ☐ No |
| Pacemaker | ☐ Yes | ☐ No |
| Blood Thinner | ☐ Yes | ☐ No |

Cardiologist: Dr.

**Weight:**__________**lbs** **Height:**__________

**Allergies:**

**Medicine allergies:**

Patient Signature Name R. Mahajan, M.D. (reviewed) Date reviewed

**OVER**

## UNITY HEALTHCARE, LLC
## DISCLOSURE AND RELEASE AUTHORIZATION FORM

**CONSENT TO TREAT:** I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

____________ **Initials**

**RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS:** I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

____________ **Initials**

**FINANCIAL AGREEMENT:** I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account of future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.

____________ **Initials**

**TELEPHONE CONTACTS:** I authorize Unity Healthcare, LLC and its affiliates and agents to contact me at the phone numbers I have provided (whether such is a cell phone or a land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me. If a machine or voice mail is reached I understand a message may be left for me. (If you are receiving treatment from multiple Unity Healthcare providers, it may result in multiple calls.)

____________ **Initials**

**NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have been offered a copy of the Unity Healthcare's Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

____________ **Initials**

**INDIANA LAW AND JURISDICTION:** I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

____________ **Initials**

**NOTICE OF NONDISCRIMINATION:** Unity Healthcare, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender identity.

____________ **Initials**

**OTHER PROVIDERS:** I understand in addition to the attending physician, other physicians, such as radiologists and pathologists, and other providers such as laboratories and other medical professionals, may be involved in my care, and may separately bill me for their services.

____________ **Initials**

**MEDICARE CERTIFICATION:** (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

____________ **Initials**

**Patient Name/Signature:** ________________________________________ Date:____________
**Parent/Guardian Signature:** ________________________________________ Date:____________