

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DOB: _____ SS#: _____ D.L.# _____

EMPLOYER: _____ COVID vaccine: _____ Dates of shots: _____

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

HOME PHONE: (____) _____ WORK PHONE: (____) _____ CELL: (____) _____

EMAIL ADDRESS: _____ COVID infection date: _____

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: _____

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.)

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.)

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: _____

PATIENT HISTORY FORM

Past Medical History	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
CAD, MI (heart disease)	<input type="checkbox"/>	<input type="checkbox"/>
COPD, lung disease.....>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high BP).....>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer.....>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyp	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer.....>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries	Yes	No
Partial hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Complete hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder	<input type="checkbox"/>	<input type="checkbox"/>
Appendix	<input type="checkbox"/>	<input type="checkbox"/>
Cesarean section	<input type="checkbox"/>	<input type="checkbox"/>
Removal of adhesions	<input type="checkbox"/>	<input type="checkbox"/>
Bladder tack	<input type="checkbox"/>	<input type="checkbox"/>
Inguinal hernia (groin)	<input type="checkbox"/>	<input type="checkbox"/>
CABG (cardiac bypass)	<input type="checkbox"/>	<input type="checkbox"/>
Tonsils/Adenoids	<input type="checkbox"/>	<input type="checkbox"/>
Gastric bypass.....>	<input type="checkbox"/>	<input type="checkbox"/>
Colon resection (removal/surgery)	<input type="checkbox"/>	<input type="checkbox"/>

List other Medical history:

List other surgeries:

Family History	Relation	Yes	No
Viral hepatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis of liver	_____	<input type="checkbox"/>	<input type="checkbox"/>
Liver cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Peptic Ulcer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/disease	_____	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	_____	<input type="checkbox"/>	<input type="checkbox"/>

	Relation	Yes	No
Crohn's Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other gastro cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	_____	<input type="checkbox"/>	<input type="checkbox"/>

Other relevant family history:

Social History		Yes	No
Tobacco	Currently?	<input type="checkbox"/>	<input type="checkbox"/>
	Quit date _____		
	Packs per day _____		
	Total # years _____		
Diet history	Low fat	<input type="checkbox"/>	<input type="checkbox"/>
	Diabetic	<input type="checkbox"/>	<input type="checkbox"/>
	Salt restricted	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol use: _____	Yes	No
Oz. per week _____	<input type="checkbox"/>	<input type="checkbox"/>
Quit date: _____		
Alcohol or drug rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____		
Last Menstrual Period _____		
Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Prosthetic heart valve	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Recent vascular graft (<1yr)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Recent joint replacement (<1yr)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pacemaker	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Blood Thinner	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Weight: _____ lbs **Height:** _____

Allergies: _____

Medicine allergies: _____

Cardiologist: Dr. _____

Patient Signature

Name

R. Mahajan, M.D. (reviewed)

Date reviewed

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

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") 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

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision. I have been informed of the information in writing by my physician's office in advance of the date of my procedure.

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 and agree to all of the following:

- a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
- b. No conditional payments accepted and payments with attempted conditions will be applied to any amounts owed.
- c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's provider, and I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
- d. I am responsible to make sure insurance payments are processed and paid promptly to my physician, and for my prompt payment of any amounts owed to Unity that are deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating provider or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services, or Unity is a non-participating provider or "out-of-network".
- e. 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 or 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.
- f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement and I agree to waive my right to a trial by jury.
- g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts and the terms of this agreement shall remain binding.

Initials

TELEPHONE CONTACTS: I authorize Unity 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 providers, it may result in multiple calls.)

Initials

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity 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 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

PHOTO CONSENT: I consent to have my photographs taken by the provider or designated associate if required, and permit use of photographs for medical records, education, and lectures.

Initials

CANCELLATIONS OR MISSED APPOINTMENTS: A fee may be charged for any appointments not cancelled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance.

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 Unity or my treating physician on my behalf.

Initials

Patient Name/Signature: _____
Parent/Guardian Signature: _____

Date: _____
Date: _____