Stephen G. Abshire, M.D., F.A.C.G.
James N. Arterburn, M.D., F.A.C.G.
Eric P. Trawick, M.D.
Jacob R. Karr, M.D.
Sylvia M. Oats, MSN, APRN, ANP-BC
Susan H. Miedecke, MSN, APRN, FNP-BC
Cynthia K. Landry, MSN, APRN, ANP-BC

Burdin Riehl Center
1211 Coolidge Blvd.
Suite 303
Lafayette, LA 70503

ph 337.232.6697
fax 337.232.3147

Dear New Patient,

Thank you for choosing our practice for your health care needs. You are scheduled with one of our physicians or nurse practitioners for an office visit at **Gastroenterology Clinic of Acadiana** (The Gastro Clinic). We are located in the **Burdin Riehl Center, Suite 303,** across the street from Lafayette General and connected by the skywalk. You may park on the 3rd floor of the attached parking tower and walk directly into our building.

Your office visit is scheduled on ___________________________. Please arrive at___________________.

We would appreciate if you would:

1. Give attention to the following documents:

   a. Please view the email that has been sent to you. You may complete the health questions online and speed up the interview process for your visit via "Patient Portal." **Visit www.gastroclinic.com for more information.**
   b. Complete Patient Information Forms and Patient Office Policy. **BRING THE COMPLETED FORMS TO YOUR SCHEDULED APPOINTMENT.**

2. Hand carry any medication you currently take. Include prescriptions and over the counter medication such as vitamins, herbal supplements, pain relievers, etc.

3. Hand carry your insurance card(s) and a pictured I.D. These are needed for each visit.

Payment is expected at time of service unless payment arrangements have been made prior to visit. Your payment can be paid online via Patient Portal, mail, or by phone. We accept MasterCard, Visa, Discover, check, and cash.
Call 232-6697 if you have any questions.

Thanking you in advance for your cooperation!

The Gastro Clinic

If you have any questions, my name is _____________________________, please feel free to contact me.

Burdin Riehl Center	Abbeville Specialty Clinic	St. Martin Hospital Campus
1211 Coolidge Blvd, Ste 303	2621 North Drive	1555Gary Drive, Ste B
Lafayette, LA 70503	Abbeville, LA 70510	Breaux Bridge, LA 70517
337-232-6697	337-232-6697	337-232-6697

PATIENT INFORMATION

PLEASE PRINT

Name ____________________

Birthdate__________ Sex__________ SS# ____________ Race:________ Marital Status:__________

Mailing Address: ____________________ City ____________ State____ Zip__________

Home Phone:____________ Work Phone:____________ Mobile Phone:____________

Email Address____________________

Employer____________________ Occupation____________________

Emergency Contact (Name of friend or relative **NOT** living with you)____________________

Home Phone____________ Additional Phone____________ Relationship __________

Address (if known) ____________________

Referring Physician ____________________

Pharmacy Name/Location ____________________ Pharmacy Phone____________

INSURANCE INFORMATION

Medicare # ____________________ Medicaid # ____________________

Primary Insurance ____________________ Eligibility & Benefits Phone Number____________

Claims Address____________________

City____________________ State__________ Zip Code____________

Electronic Payor ID ____________ Policy # ____________ Group #____________

Insured's Name____________________ Relationship to Insured____________

Insured's date of birth:____________

Other Insurance ____________________ Eligibility & Benefits Phone Number____________

Claims Address____________________

City____________________ State__________ Zip Code____________

Electronic Payor ID ____________ Policy # ____________ Group #____________

Insured's Name____________________ Relationship to Insured____________

Insured's Date of birth____________________

☐ Check box if Guarantor is self (no need to fill out section) Guarantor is the person responsible for the bill after insurance pays.

Name of Guarantor: ____________________ Phone ____________________

Address ____________________

Financial Policy We will file all insurance for you. If there is any balance owed after the insurance pays and after what you have paid today we will bill to you. We expect payment in full upon receipt of your statement unless prior arrangements have been made with the office. If no payment is received after 90 days we turn over unpaid balances to a collection agency. If we owe you money, refunds are done once a month at the end of every month. We do not refund anything under $3.00. Any questions in regards to our financial policy please ask for our Business Office Manager. **Pt /Guardian Initials** __________

Patient or Legal Guardian Signature____________________ Date____________

Rev 7/09, 5/10, 10/13

CONSENT FOR TREATMENT AND FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Gastroenterology Clinic of Acadiana, LLC creates and maintains health records describing my health history. I understand the Gastroenterology Clinic of Acadiana, LLC may use this information as:

1. A basis for planning my care and treatment,
2. A means of communication among many health professionals who contribute to my care,
3. A means by which third-party payers can verify that services billed were actually provided,
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals, and
5. A means by which licensing, accreditation, and regulatory agencies can verify that appropriate quality services are provided.

I consent to treatment at Gastroenterology Clinic of Acadiana, LLC under the care of Dr. Stephen G. Abshire and Dr. James N. Arterburn, their associates, partners, assistants, or designees. I consent to any or all outpatient care, which encompasses the following as ordered by my physician: interview, physical examination, x-ray examination or fluoroscopy, laboratory procedures, diagnostic procedures, conscious sedation or local anesthesia, and nursing or medical treatment which my physician may deem necessary or advisable.

I consent to the use and disclosure of my personal health information by Gastroenterology Clinic of Acadiana, LLC for the purposes of treatment, payment, and healthcare operations. I authorize Gastroenterology Clinic of Acadiana, LLC to apply for benefits on my behalf of covered services. I request payment from my insurance company be made directly to Gastroenterology Clinic of Acadiana, LLC.

Patient Signature: ___________________________________ Witness: ________________________

If patient is a minor or unable to sign:

Patient Representative: _______________________________Relationship:_____________________

Printed Name of Patient: _______________________________ Date: ________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- **I have received a copy of this office's Notice of Privacy Practices.**

- **You may disclose my health information to the following people: [please state name and relationship; you may also list their phone number(s) if you would like us to contact them in the event we are unable to reach you]:**

  ____

  ____

  ____

  ____

  ____

*****Please note that no information will be given to anyone not listed above*****

- **Please identify the means by which you prefer we contact you (check all that apply):**
  - ☐ **Home Phone**
  - ☐ **Answering machine message**
  - ☐ **Work phone**
  - ☐ **Voice mail message**
  - ☐ **Cell Phone**
  - ☐ **Other (please specify):** ______________________________

- **Is there anyone other than yourself you would like for us to speak with regarding insurance and billing matters?**
  Yes No (Please circle)

  If yes, please state name, relationship and phone number they can be reached:

  Name: ______________________________ **Phone:** ______________________________

- ______________________________ ______________________________
  Patient Signature **Patient Printed Name**
  If patient is a minor or unable to sign:

  ______________________________ ______________________________
  Patient Representative **Relationship to Patient**

  ____
  Date

For office use only:
In lieu of patient signature, I, ______________________________, an employee of Gastroenterology Clinic of Acadiana, state that the above named patient has been given our current Notice of Privacy Practices.

______________________________ ______________________________
Employee Signature **Date**

Gastroenterology Clinic of Acadiana, LLC

OFFICE POLICY

Welcome to the Gastroenterology Clinic of Acadiana (Gastro Clinic). In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our office policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card and pictured ID at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. You will be asked to provide us with up to date health information at each visit so that we can treat your health issues as a priority.
3. If you have a change of address, telephone number, employer, etc., please notify our office at 337-232-6697.
4. Patients need to be aware that The Gastro Clinic is a specialty consultant clinic. The physicians/nurse practitioners of The Gastro Clinic are NOT primary care providers.
5. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, and Discover.
6. **Medicare Patients:** We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
7. **Insurance covered Patients with plans that we participate with:** If we participate with your plan, we will bill your insurance for you. Your co-payment/co-insurance will be collected at the time of service - no exceptions. If your plan requires you to have an authorization to see a specialist, YOU will need to obtain the authorization from your PCP.
8. **Insurance covered Patients with plans that we do not participate with:** If we do not participate with your plan, we will verify your out-of-network benefits, file your charges, and will expect payment of your portion of the charges at the time of service.
9. If insurance denies charges and/or does not pay your claim within 60 days, we have the right to turn the entire balance over to you.
10. **Self-Pay Patients:** *Established* patients with no insurance will be expected to pay at the time of service.
New self-pay patients must put down a deposit prior to services rendered.
11. **Procedures Scheduled:** You will be required to pay your portion of the physician charges at least 48 hours prior to the day of the procedure scheduled. Failure to pay may result in cancellation of your procedure.
12. **Screening Colons:** During your screening colonoscopy if a biopsy, polypectomy, or snare procedure needs to be done, then the procedure changes from a screening to a therapeutic procedure. Your insurance may pay in a different manner.
13. If your account becomes delinquent, we reserve the right to refer your account to a collection agency and to be reported to the credit bureau. Any fees assessed by the collection agency will be the patient's responsibility. Delinquent account refers to non-payment 90 days after the balance becomes your responsibility.
14. Be aware this office bills only for Physicians and Nurse Practitioners of The Gastro Clinic. Separate charges from the Facility (ex. LGEC), Pathology and/or Anesthesiology, etc. depending on your procedure, will apply.
15. **No Shows or Missed Appointments**: An appointment scheduled with the provider is time specifically allocated for you. Failure to cancel 24 hours in advance will result in a $50 charge to the patient (this is not filed with insurance).
16. The MD has discretion to discharge the patient back to primary physician at any point once specialty concerns have been addressed.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding this office policy, please feel free to contact us at www.gastroclinic.com.

I have read and have a full understanding of the policies of Gastroenterology Clinic of Acadiana.

Patient	Date
Representative Signature	Relationship to Patient
Witness	Guarantor Signature Required (For Minor in non-emergent situation)

GASTROENTEROLOGY CLINIC OF ACADIANA, LLC
337.232.6697
NOTICE OF PRIVACY PRACTICES

Effective Date: March 26, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**.

Each time you visit our facility a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by this facility and its Physicians and personnel.

OUR RESPONSIBILITIES
We are required by law to maintain the privacy of your health information as well as ePHI and provide you a description of our privacy practices. We will abide by the terms of this notice.

USES AND DISCLOSURE
How we may use and disclose medical information about you.
For treatment: We may use medical information about you to provide treatment or services to you. We may disclose medical information to our doctors, our nurses or other clinical personnel this is to coordinate the different things you may need, such as prescriptions, lab work, and x-rays. We may provide to your referring physician or a subsequent healthcare provider (a physician, hospital, or outpatient facility) a copy of your medical information to facilities your testing or treatment. For example: Your doctor may order an ultrasound of your abdomen and it will be done at your local hospital. The radiology doctor will need to know your symptoms in order to evaluate your ultrasound appropriately.
For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. For example, we may need to give your insurance company information about your examination so they will pay us for your treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.
For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine medical information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purpose. We may combine medical information we have with that of other similar facilities to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy. We may also use and disclose medical information:

- To business associates we have contacted with to perform the agreed upon services and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives or health-related benefits or services;
- For population based activities related to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professionals

Business Associates: There are some services provided in our facility through contracts with business associates. For example: The dieticians provide diet instructions under contract. We may disclose your health information to our business associate so they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however we require the business associate to appropriately safeguard your information.
Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.
Research: We may disclose information to researches when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.
Future Communications: We may communicate with you via newsletter, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.
As Required by Law: We may also use and disclose health information for the following types of entities, including but not limited to:
Food and Drug Administration, Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability. Correctional Institutions, Workers Compensation Agents, Organ and Tissue Donation Organizations, Military Command Authorities, Health Oversight Agencies Funeral Directors, Coroners and Medical Directors, National Security and Intelligence Agencies, and Protective Services for the President and Others
Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: We may disclose health information to the State Public Health Department for the purpose of improving health and reducing health care costs.

Authorization: Without your authorization, we may not use or disclose your psychotherapy notes, we may not use or disclose your health information for our own marketing, and we may not sell your health information.

Breach Notification: We are required to maintain the privacy of your health information and, to provide you with notice of our legal duties and privacy practices relating to your health information. If there is a breach (an inappropriate use or disclosure of your health information that the law requires us to report), we must notify you.

You're Health Information Rights

Although your health record is the physical property of the healthcare provider that compiled it, you have the right to:

- **Inspect and copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances.
- **Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of you medical information for purposes other than treatment, payment or health care operations.
- **Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request. If we do agree, we will comply with your request unless the information needed is needed to provide you emergency treatment. You have the right to request that we not use or disclose your health information. If you request that we not disclose your information to your insurer about a specific health product or service, and you pay for that product or service, we must agree to your request. Otherwise, we are not required to agree to the restrictions you request.
- **Request Confidential Communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or by the U.S. Mail. The facility will grant requests for confidential communications at alternative locations and/or by alternative means only if the requests include a mailing address where the individual will receive bills for services for rendered by the facility and related correspondence regarding payment for services. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website (www.gastroclinic.com).

To exercise any of your rights, submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and include the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with this facility by calling the main phone number and asking for the Facility Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be given in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Patient Interview Form

Patient Information

First Name:______________________ Last Name:______________________

MRN:______________________ Date Of Birth:______________________

Age:______________________

Email

Please check one as your preferred email for communications

- ◯ Personal:______________________
- ◯ Work:______________________

Preferred Language

- ◯ English
- ◯ French
- ◯ Patient declines to specify

Contact Preference

- ◯ Patient Portal
- ◯ Home Number
- ◯ Cell Phone
- ◯ May leave a message on machine
- ◯ All of the Above
- ◯ Patient declines to specify

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Sex

- ◯ Male
- ◯ Female
- ◯ Other

Race

Select one or more

- ◯ White
- ◯ Black or African American
- ◯ Asian
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Unknown
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Pharmacy

____

Name Address Phone

Printed on 8/31/2016

Allergies

- [ ] Patient has no known allergies
- [ ] Patient has no known drug allergies

Drug Allergies:

◯ Aspirin	◯ Codeine	◯ Iodine	◯ Penicillins
◯ Sulfa	◯ Latex	◯ Surgical Tape	Other:____________

Current Medications

◯ None

Name	Dose	How taken?

Immunizations

◯ None

◯ Flu Vaccine	◯ Hepatitis B	◯ Hepatitis A	◯ Pneumonia	◯ Shingles
When:____________	When:____________	When:____________	When:____________	When:____________

Diagnostic Studies/Tests

◯ None

◯ Colonoscopy	◯ EGD	Other:____________
When:____________	When:____________	

Past or Present Medical Conditions

◯ None

◯ Anemia When:____________	◯ Hepatitis A When:____________	◯ Barrett's Esophagus When:____________	◯ History colon polyps When:____________	◯ Celiac Disease When:____________
◯ Autoimmune Disease When:____________	◯ Hepatitis B When:____________	◯ GERD When:____________	◯ History of Colon Cancer When:____________	◯ Pancreatitis When:____________
◯ Fatty liver When:____________	◯ Hepatitis C When:____________	◯ Gastric Ulcer When:____________	◯ Crohn's Disease When:____________	◯ Gallbladder Disease When:____________
◯ Cirrhosis, Liver When:____________	◯ HIV When:____________	◯ Trouble swallowing When:____________	◯ Ulcerative Colitis When:____________	◯ Diverticular Disease When:____________

Other:____________

Other Medical Conditions:

◯ Asthma When:____________	◯ C.O.P.D. or lung problems When:____________	◯ Emphysema When:____________	◯ Congestive Heart Failure When:____________
◯ Sleep apnea When:____________	◯ Home oxygen When:____________	◯ Blood thinners When:____________	◯ Pacemaker/ Defibrillator When:____________
◯ Supraventricular Arrhythmia (SVT) When:____________	◯ Atrial Fibrillation (AFIB) When:____________	◯ Previous Heart Attack When:____________	◯ Stroke When:____________
◯ Artificial Heart Valve When:____________	◯ Kidney disease When:____________	◯ Dialysis When:____________	◯ Seizures When:____________

- ⬭ Hypertension uncontrolled by medication When:______________
- ⬭ Hypertension- controlled by medication When:______________
- ⬭ Tuberculosis, Exposure When:______________
- ⬭ Diabetes Mellitus When:______________
- ⬭ Mitral Valve Prolapse/MR When:______________
- ⬭ Glaucoma When:______________
- ⬭ HX of Cancer When:______________
- ⬭ Rheumatoid Arthritis When:______________
- Other:______________

Previous Procedures

- ⬭ None

- ⬭ Nissen Fundoplication When:______________
- ⬭ Gastric By-Pass When:______________
- ⬭ Appendectomy When:______________
- ⬭ Gallbladder Surgery When:______________
- ⬭ Colon Resection When:______________
- ⬭ Hemorrhoidectomy When:______________
- ⬭ Hernia Repair When:______________
- Other:______________

Other Surgical Procedures:

- ⬭ C-Section When:______________
- ⬭ Hysterectomy When:______________
- ⬭ Heart stents When:______________
- ⬭ Open heart surgery When:______________
- ⬭ Joint Replacement When:______________
- Other:______________

Social History

Number of Children:______________________________

Marital Status

⬭ Single ⬭ Married ⬭ Divorced ⬭ Widowed ⬭ Other

Alcohol

⬭ None

Type	Quantity	Frequency
⬭ Beer		
⬭ Hard liquor		
⬭ Wine		

Caffeine

⬭ None

⬭ Coffee ⬭ Energy Drinks ⬭ Soda ⬭ Tea ⬭ Other

Tobacco

Smoking Status

- ⬭ Current every day smoker
- ⬭ Current some day smoker
- ⬭ Former smoker
- ⬭ Never smoker
- ⬭ Smoker, current status unknown
- ⬭ Light tobacco smoker
- ⬭ Heavy tobacco smoker
- ⬭ Unknown if ever smoked

Drug Use

⬭ None

⬭ IV Drugs ⬭ Other

Exercise

- [ ] None
- [ ] Daily
- [ ] 1-3 times per week
- [ ] 4-6 times per week
- [ ] Rarely

Family Medical History

- [ ] No knowledge of family history

No family history of
- [ ] Colon Cancer
- [ ] Colon Polyps
- [ ] Crohn's Disease
- [ ] Gallbladder Disease

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle	First Cousin	Other
Esophageal Cancer												
Stomach Cancer												
Colon Cancer												
Colon Polyps												
Inflammatory Bowel Disease												
Celiac Disease												
Diabetes												
Breast Cancer												
Endometrial/Ovarian Cancer												
Gallbladder Disease												
Heart Disease/Hypertension												
Stroke												

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- [ ] Yes
- [ ] No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

- [ ] Yes
- [ ] No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

- [ ] Yes
- [ ] No

Review of Systems

Genitourinary - (Women Only)

	YES
None	☐
Bleeding between periods	☐
Breast problems during menstrual periods	☐
Can you become pregnant?	☐
Current menstrual clots/cramping/flooding	☐
Miscarriages/stillborns	☐
Post-menopausal	☐
Problems with menstrual periods	☐
Vaginal itching or discharge	☐
Vaginal trauma	☐

Allergic/Immunologic

None	☐
Allergy shots	☐
Chemotherapy/Radiation	☐
Environmental allergies	☐
Food allergies	☐
Immune disorder	☐

Cardiovascular

None	☐
Ankle swelling	☐
Blood pressure	☐
Chest pain/angina	☐
Heart surgery/heart stent	☐
Leg cramps at night/pain	☐
Leg pain	☐
Heart disease or murmur	☐
Painful/numb/white/blue fingers	☐
Palpation (thumping/racing of heart)	☐

Constitutional

None	☐
Fatigue/lack of energy	☐
Health status	☐
Night sweats/fever/chills	☐
Weight gain	☐
Weight loss	☐

ENMT

None	☐
Blurred vision	☐
Canker sores/burning tongue	☐
Cataracts	☐
Contact lens	☐
Hearing impaired	☐
Hoarseness/sore throat	☐
Irritated eyes	☐
Nosebleeds	☐
Recent change in sight	☐
Ringing/buzzing/draining in ears	☐
Stuffy nose/post nasal drips/sinus attack	☐
Swollen glands in neck	☐
Trouble with gums/teeth	☐

Endocrine

None	☐
Changes in skin or hair or nails	☐
Diabetes	☐
Excessive thirst	☐
Excessive urination	☐
Glandular disorder	☐
Intolerance to heat/cold	☐
Thyroid disorder	☐

Gastrointestinal

	YES
None	☐
Abdominal pain	☐
Abdominal swelling/abdominal fluid	☐
Blood in stools	☐
Change in bowel movements	☐
Change/loss of appetite	☐
Choking or gagging when eating	☐
Constipation	☐
Diet restrictions	☐
Food allergies	☐
Frequent diarrhea	☐
Gallbladder disease	☐
Heartburn/reflux	☐
Hemorrhoids (piles)	☐
Hepatitis	☐
Jaundice/liver disease	☐
Nausea/upset stomach	☐
Painful bowel movements	☐
Pale/clay colored stools	☐
Rectal itching	☐
Rectal pain	☐
Trouble swallowing	☐
Unbalanced diet	☐
Vomiting	☐
Vomiting of blood	☐
Anal insertions	☐
Rectal trauma	☐
Hernias	☐

Genitourinary

None	☐
Blood in urine	☐
Difficulty passing urine	☐
Frequent urination	☐
High risk sexual activity	☐
Impotence	☐
Kidney stones/colic	☐
Kidney/bladder infections	☐
Painful/burning urination	☐
Prostate trouble	☐
Wake up at night to urinate	☐
Incontinence/leaky bladder	☐

Hematologic/Lymphatic

None	☐
Abnormal bleeding	☐
Anemia	☐
Bleeding or bruising tendencies	☐
Blood disorder	☐
Blood transfusion	☐
Cancer	☐
Enlarged glands	☐
Phlebitis/blood clots	☐
Slow to heal after cuts	☐
Tattoo/body piercings	☐

Integumentary

	YES
None	☐
Breast discharge/lump/pain	☐
Bruise easily	☐
Change in hair or nails	☐
Change in mole/scar	☐
Finger sensitivity to hot or cold	☐
Rash or itching	☐
Skin disorder	☐
Unusual itching	☐
Date of last mammogram	☐

Musculoskeletal

None	☐
Joint pain/stiffness/swelling	☐
Muscle cramps/weakness	☐
Neck pain/stiffness	☐
Severe backache/headache	☐
Date of last bone density	☐

Neurological

None	☐
Convulsions	☐
Difficulty talking	☐
Frequent or recurring headaches	☐
Hypersensitivity	☐
Light headed or dizziness	☐
Migraines/sick headaches	☐
Numbness or tingling sensation	☐
Paralysis	☐
Sick headaches	☐
Stroke	☐
Tremors	☐
Weakness	☐

Psychiatric

None	☐
Confusion	☐
Consulted psychiatrist	☐
Depression	☐
Difficulty making decisions	☐
Easily irritated or upset	☐
High-strung personality	☐
Insomnia	☐
Melancholy	☐
Memory loss	☐
Nervousness	☐
Recent stressful events	☐
Tenseness	☐
Trouble sleeping	☐
Uncontrollable anger	☐
Unpleasant work or home	☐
Worry excessively	☐

Respiratory

None	☐
Asthma	☐
Bloody sputum	☐
Cough, persisting	☐
Shortness of breath	☐
Sleep propped up at night	☐
Smothering spells at night	☐
Sputum (phlegm, mucus)	☐
Wheezing	☐
Tobacco use	☐

Patient Name: ___________________________________ Date: __________________________

Please provide a list of all of your current medications including prescriptions, over the counter, vitamins, or herbal supplements.

Medication Name:	Strength:	How many times a day:
Example: Nexium	40mg	One tablet every morning
____________________	______________	________________________
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Allergies: ____

GASTROENTEROLOGY CLINIC OF ACADIANA LLC
1211 Coolidge Blvd., Suite 303
LAFAYETTE, LA 70503

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	
ADDRESS:	
PROVIDER AUTHORIZED TO RELEASE THE HEALTH INFORMATION (THE PROVIDER):	(Name of releasing entity)
ENTITY TO RECEIVE THE HEALTH INFORMATION (THE RECIPIENT):	(Name of receiving entity)
RECIPIENT'S ADDRESS:	

DATES OF SERVICE OF THE HEALTH INFORMATION THAT IS COVERED BY THIS AUTHORIZATION:

START DATE:	END DATE:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

	YES		NO	PROGRESS NOTES		YES		NO	DISCHARGE SUMMARY
	YES		NO	LABORATORY TESTS		YES		NO	COMPLETE HEALTH RECORD
	YES		NO	X-RAY REPORT		YES		NO	OTHER(PLEASE SPECIFY):
	YES		NO	CONSULTATION REPORTS					
	YES		NO	HISTORY & PHYSICAL EXAM					

☐ If checked, this is a conditional authorization, and you will not receive the following services unless you sign this authorization (describe any consequences of refusing to sign):

PURPOSE OF USE OR DISCLOSURE:

AUTHORIZATION EXPIRATION DATE OR EVENT:

This authorization to release the health information listed above can be revoked at any time (upon written notification to the Recipient at the above address) except to the extent that (1) Provider has already released the Health Information before being notified of the revocation, or (2) Provider has taken action in reliance on this authorization. Provider's Notice of Privacy Protections contains more information on how to revoke this authorization. This authorization will expire on the expiration date or event listed above.

When the Patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the Recipient or any of its agents and/or employees and may no longer be protected by 45 CFR Parts 160 and 164.

The undersigned patient (or personal representative on behalf of the patient) hereby authorizes the Provider named above to release the Health Information described above to the Recipient named above. The patient has the right to refuse to sign this authorization.

The provider can condition treatment, payment, enrollment, or eligibility for benefits on the patient providing this signed authorization,except in very limited circumstances. If this is one of those circumstances, the consequences of refusing to sign are described above.

The Patient has the right to inspect and copy his health information that is included in a designated record set, subject to the exceptions found in 45 CFR 164.524.

SIGNATURE:	DATE:
AUTHORITY TO SIGN IF NOT PATIENT:	