DIGESTIVE HEALTH SERVICES

A Division of GI Partners of Illinois, LLC

ROCKFORD G. YAPP, M.D., M.P.H.
JAMES R. CLARK, M.D.
ANSHUMAN CHAWLA, M.D.
LESLEY K. DAWRAVOO, M.D.

PATIENT INFORMATION			
Last Name:	First Name:	Middle:	Date of Birth:
Gender:	SSN:	Race:	Marital Status:
Address:	City:	State:	Zip Code:
Primary Phone:	county:	Email Address:	
Alternate Phone:	Primary Care Physician (full name/phone number)		

EMERGENCY CONTACT INFORMATION			
First Name:	Last Name:	Phone Number:	Relationship:

PRIMARY INSURANCE INFORMATION			
Insurance Name:	Policy Number:	Group Number:	
Subscriber:	Relationship:	Date of Birth:	SSN:

SECONDARY INSURANCE INFORMATION			
Insurance Name:	Policy Number:	Group Number:	
Subscriber:	Relationship:	Date of Birth:	SSN:

PHARMACY INFORMATION		
Pharmacy Name:	Address:	Phone Number:

Due to HIPAA regulations, we are unable to give information such as biopsy and lab results to anyone not listed on this form. Please list the following people you give consent for your information to be given to:

NAME	RELATIONSHIP

There will be a $50.00 fee for failing an appointment in the office and a $250.00 fee for failing an appointment for any procedure, without 48 hour notice.

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name: _____ Date: _____

Reason for Visit: _____

Have you ever had a colonoscopy or Upper Endoscopy? Yes No If so, when? _____

Performing Doctor's Name or Facility: _____

Do you have a Pacemaker and/or Defibrillator? Yes No Are you on Blood Thinners? Yes No

If yes, who prescribes it? _____

Current Medications:

_____

_____

_____

_____

_____

Allergies: _____

Surgeries: _____

_____

_____

_____

Recent Hospitalizations / ER Visits: Yes No When? _____ Which Hospital? _____

Please circle any personal history of the following: Hepatitis A/B/C Kidney Disease Liver Disease

Crohn's Disease/UC Cancer: List Type: _____

List any other medical conditions:

_____

_____

_____

_____

_____

CURRENT SYMPTOMS

Patient Name: _____ Date: _____

Change in Primary Care Physician or Pharmacy: _____

Mark all CURRENT symptoms:

Allergic/Immunologic
- HIV Exposure
- Persistent infections

Cardiovascular
- Chest pain
- Irregular heartbeat
- Palpitations

Constitutional
- Fatigue
- Fever
- Loss of appetite
- Sweats
- Weight gain
- Weight loss

ENMT
- Nosebleeds
- Sore throat
- Sinus trouble
- Loss of voice

Endocrine
- Excessive thirst
- Hair loss
- Heat intolerance

Eyes
- Double vision
- Loss of vision
- Sensitivity to light

Gastrointestinal
- Abdominal pain
- Abdominal swelling
- Change in bowel habits
- Constipation
- Diarrhea
- Gas
- heartburn
- Jaundice
- Nausea
- Rectal bleeding
- Rectal pain
- Stomach cramps
- Vomiting
- Difficulty swallowing
- Black stool

Genitourinary
- Dark urine
- Decrease in urine flow
- Painful urination
- Frequent urinary infections
- Frequent urination
- Blood in urine
- Need to urinate at night

Hematologic/Lymphatic
- Bleeding gums
- Palpable lymph nodes
- Easy bruising
- Prolonged bleeding

Integumentary
- Allergies
- Dryness
- Hives
- Itching
- Lesions
- Rashes

Musculoskeletal
- Arthritis
- Back pain
- Gout
- Joint pain
- Muscle weakness
- Stiffness

Neurological
- Dizziness
- Fainting
- Frequent headaches
- Migraine
- Numbness/Tingling
- Seizures
- Tremors
- Vertigo

Psychiatric
- Anxiety
- Depression
- Hallucinations
- Panic attacks
- Nervousness
- Paranoia

Respiratory
- Asthma
- Cough
- Shortness of breath
- Excessive phlegm
- Coughing up blood
- Wheezing

Patient Signature: _____ Date: _____

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Corporate Office
1880 W. Winchester Rd
Suite 104
Libertyville, IL 60048
http://www.gipartnersofil.com/

Financial Policies

Thank you for choosing GI Partners of IL, LLC as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. As a patient, the clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please feel free to ask any questions about our fees, policies, or patient responsibilities.

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are **due at time of service** unless previous arrangements have been made. If you are unable to pay at the time of your visit, we reserve the right to reschedule your appointment to a later date.

Insurance Claims

Your health insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. To properly bill your insurance carrier, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It will be your responsibility to notify our office of any pertinent information changes (i.e. address, name, insurance information, etc.). Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Pre-Authorizations

Certain health insurance plans (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or nonpayment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

You understand and agree that (regardless of my insurance status), that you are ultimately responsible for the balance on your account for any services rendered. You hereby authorize GI Partners to release to your insurance company, any information including diagnosis & medical records of any treatment or examination rendered. You also authorize and request your insurance company to pay GI Partners directly, the amount due after applicable payments are made by you.

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Medicare Patients
We accept Medicare assignment. Therefore, you will be responsible for the balance on your account after Medicare's processing/payment. If you have supplemental insurance, we will bill the balance to that insurance company. Subsequently, any remaining balances are your responsibility.

Self-Pay Accounts
Arrangements must be made regarding payment prior to scheduling an appointment or procedure. Payment in full is due at time of service for office visits. Payment in full is due at least 3 days prior to a scheduled procedure.

No Show/Cancellations
We require a 24-hour notice for any office visit cancellation. Failure to provide the 24-hour notice may result in a $50.00 fee being assessed. Three "no shows" may result in discharge from the practice. We require a 48-hour notice for cancellation or rescheduling of procedures. Failure to provide the 48-hour notice may result in a $250.00 fee being assessed.

Statements and Collections
Patient statements are sent monthly. Payment in full is due upon receipt of statement unless other arrangements have been made. In the event the balance is still outstanding after 90 days the account may be forwarded to an outside collection agency.

Payment Methods
For your convenience we accept Cash, Check, Money Orders, Visa, Mastercard, American Express and Discover. Any checks returned for nonsufficient funds will incur a $40.00 service charge. Another form of remittance will be required for the balance due.

Form Fees
Our practice charges for additional paperwork outside of the completion of medical records. Single page forms - $25.00, multi-page forms -$50.00, complex non-standard FMLA and disability forms - $85.00

Medical Records
Copies of medical records are available upon request. The practice charges a fee for copies in accordance with the State of IL Comptroller's Office. This fee schedule is available upon request.

I have read and understand the financial policy set forth by GI Partners. I understand that I am responsible for having the appropriate referral or authorization on file prior to my scheduled appointment. I understand that I am responsible for the "Patient Due" portion of my statement. I understand that if I do not observe this financial policy, GI Partners has the right to use other means of collection for my outstanding balance.

Patient Signature: _____ Date: _____

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1880 W. Winchester Rd
Suite 104
Libertyville, IL 60048
www.gipartnersofil.com/

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION
RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I acknowledge receipt of the GI Partners of Illinois, LLC Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available on next office visit. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I,_____, herby give my consent to GI Partners of Illinois, LLC for the purpose of carrying out treatment, payment, or healthcare operations to use and disclose all information contained in the patient record of_____ *(patient's name)*

May our office leave a message on your voicemail/answering machine:

____YES _____ NO

Phone Number(s):_____

_____ No one other than myself may have access to my medical records.

The following person(s) listed below have my permission to discuss my medical history, conditions and treatment with the physician and staff at GI Partners of Illinois, LLC. This permission remains in effect until I cancel (all or in part) by notifying GI Partners of Illinois, LLC in writing.

Name & Relationship to patient: _____

Name & Relationship to patient: _____

Name & Relationship to patient: _____

Patient Signature: _____ Date: _____

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PATIENT DISCLOSURE

By

Midwest Center for Day Surgery, LLC

3811 Highland Avenue

Downers Grove, IL 60515

Doctors Yapp, Clark, Chawla and Dawravoo have an ownership interest in the Midwest Center for day Surgery (MCDS).

Please be aware that there is no requirement that your surgery be performed at Midwest Center for Day surgery and you are free to seek surgical services at any facility of your choice. All patients will be treated in the same manner, regardless of where they choose to obtain surgery services.

Should you desire information pertaining to surgical facilities located within 10 miles of Midwest Center for Day Surgery, please contact a staff member.

Accepted and Agreed:

_____ Date: _____

Patient Name

_____

Patient Signature

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Informed Consent for Pathology Services
Gastrointestinal Endoscopy

I understand and agree that during my gastrointestinal endoscopy, biopsies my be taken, as part of routine endoscopic care. I consent to pathology services when needed.

I understand and agree that GI Partners processes their biopsies in their own pathology lab. A GI Partner pathologist, expert in reading gastrointestinal biopsies, will read the biopsies to make a diagnosis.

I understand and consent to the use of images of my de-identified biopsies for research and development purposes. In such an event, my name and personal information will not be shared.

GI Partners of Illinois, LLC would like to improve the efficiency with which Pathologists make GI diagnosis. I understand and accept that GI Partners, LLC has a financial interest in an artificial intelligence company designed to improve the efficiency with which Pathologists make GI diagnosis.

Patient Signature: _____ Print Name: _____

Legally Authorized Representative: _____

Relationship to Patient: _____

Date: _____ Time: _____