HOLSTON MEDICAL GROUP
Multi-Specialty Physician Practice

105 West Stone Drive, Suite 4-C • Kingsport, TN 37660 • Telephone (423) 578-1595 • Facsimile (423) 578-1596

Gastroenterology

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Thank you for choosing Holston Medical Group Gastroenterology. We are honored to participate in your care. We would like to take this time to inform you about the **TYPE** of colonoscopy you may have.

There are **THREE** (3) categories in which you may fall into, depending on why you are undergoing the procedure.

1. **Diagnostic/Therapeutic**
   - Patient has a gastrointestinal sign, symptom and or diagnosis.
   - Example: Rectal bleeding, anemia, diarrhea, change in bowel habits.

   _______ **initial**

2. **Preventive/Screening**
   - Patient is 50 years of age or older.
   - Patient does **NOT** have any gastrointestinal sign, symptom(s) and/or relevant diagnosis.
   - Patient does **NOT** have any **PERSONAL** history of colon cancer, polyps, and/or gastrointestinal disease.
   - Patient may have a family history of gastrointestinal sign, symptom(s) and/or relevant diagnosis.
   - Can be performed once every 10 years aged 50-75

   _______ **initial**

   ****NOTE****
   If a polyp is found during a preventive/screening colonoscopy your insurance may not pay at 100%. Please check with your insurance company to check YOUR policy coverage.

3. **Surveillance**
   - Can be performed at varying ages and intervals based on the patient's **PERSONAL** history of colon cancer, polyps, and/or gastrointestinal disease.
   - Patients with a history of colon polyp(s) are **NOT** recommended for a **SCREENING** colonoscopy.

   _______ **initial**

PLEASE CALL your insurance company prior to having any procedure done to check on your benefits and coverage. Your insurance company may state that they do agree that it is medically necessary for you to have the procedure done but does not guarantee payment.

If your insurance does not pay, please remember that you will be responsible for payment to the Doctor and to the Surgery Center or Hospital, where you have your procedure done.

If you have any questions, please ask your provider during your visit or you may call our Kingsport office (423) 578-1595 or Bristol office (423) 990-2426 for answers and clarification.

Thank you once again for choosing Holston Medical Group Gastroenterology.

____ _______________________
Signature Date

Welcome to our office

Where did you hear about us?

❒ Yellow Pages (YP) ❒ Newspaper (NP) ❒ Website (WS)
❒ Friend or Family (FF) ❒ Physician Referral (PR)
❒ Other (OT) ______

OFFICE USE ONLY
Physician:______
Approved by:______
Date:______

NEW PATIENT INFORMATION (Complete if different from billing party)

Name______ First ______ Middle ______ Last

Address______

City______ State______ Country ______Zip______ Phone # (____)______

Birthdate______ Sex M or F Race______ Marital Status S M W D

Social Security #______ Employer______

Address of Employer______ Work Phone #______

May we contact you at work? Y N By E-Mail Y N E-Mail Address ______

Emergency Contact Name______ Emerg. Phone # (____)______

Relationship to billing party______

Guarantor/Responsible Party

Name______ First ______ Middle ______ Last

Address______

City______ State______ Zip______ Phone #______

Birthdate______ Sex M or F Marital Status S M W D

Social Security #______ Driver's License #______

Place of employment______ Work Phone #______

OTHER INFORMATION

Name and address of nearest relative not living with you______

Address______City______ State______ Zip______ Phone #______

If you are currently under another physician's care, please list:

Name______

Address______City______ State______ Zip______

Whom may we thank for referring you to us?______

INSURANCE

1. Primary Insurance Company Name______

Group #______ Policy Member #______

Subscriber Name______ Subscriber Birthdate______ Sex M or F Social Security #______

Subscriber Employer and Address______

2. Secondary/Supplemental Insurance Name______

Group #______ Policy/Member #______

Subscriber Name______ Subscriber Birthdate______ Sex M or F Social Security #______

Subscriber Employer and Address______

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.

By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date______ Signature______

MRN: ______________________________

DATE RECEIVED: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices,* which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on Holston Medical Group's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically, or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

____ ____________________

Print Patient Name Patient Date of Birth

____ ____________________

Patient Signature (if applicable) Date

____ ____________________

Authorized Representative Signature Relationship to Patient

I understand that my protected health information will only be verbally communicated to those individuals listed below. Those individuals will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individuals that you want protected health information given to:

______________________________ ______________________________

______________________________ ______________________________

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained:

____

____

____

____ ____________________

Employee Signature Date

NO SHOW POLICY

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least two hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients that fail to show up for a scheduled appointment **may be charged a fee** for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

______________________________	______________________	______________________
Please Print Patient Name	Date of Birth	Account Number

______________________________	______________________________
Please Sign Authorized Representative	Relationship to Patient

______________________________	______________________________
Witness	Date

	First	Middle	Last
NAME:			

GENERAL State of Health
Excellent Good Fair Poor

Marital Status:
Single Married Widowed
Separated Divorced

Occupation or Job:

Number of Children:

Number of People in Household:

Do you Smoke? ☐ Yes ☐ No
Packs per Day
Number of Smoking Years

Do you Drink Alcoholic Beverages?
How Much?

Are you on any type diet?
Type:

Religion: Protestant Denomination
Catholic
Other

YOUR IMMUNIZATIONS:

Adults		Date of Last Booster
	1. Polio	
	2. Tetanus	
	3. Diptheria	

When did you have your last physical exam:
Year_______ Result________________ Vision Test__________
TB Skin Test___________________Chest X-ray____________
Pap Smear_____________ Glaucoma (Eye)________________
Were any of the tests positive? ___________________________

Have you had your stool checked for blood?________________
Have you ever had a flexible sigmoidoscopy?_______________
Do you have heart mummers or had
antibiotic prophylaxis? _____________________________
Drug Allergies:_____________________________________

Previous Hospitalizations and/or Surgery (ies)

	Illiness	Date
1.		
2.		
3.		
4.		

CURRENT MEDICATIONS (Include over the counter)

1.	5.
2.	6.
3.	7.
4.	8.

Form of Birth Control:

Chart______________________

Doctor _____________________

Date history was received: ____________

Date of Birth:

FAMILY HISTORY

	Age	Present Illiness	Cause of Death
Mother			
Father			
Brothers & Sisters			
1.			
2.			
3.			

Is There a Family History of: *(Check Appropriate Box)*

High Blood Pressure		Depression	
Sugar Diabetes		Psychiatric Illness	
Overweight		Alcoholism	
High Cholesterol		Bleeding Disorder	
Heart Attack		Anemia	
Stroke		Glaucoma	
Tuberculosis		Cancer	
Lung Problem		A. Lung	
Asthma		B. Breast	
		C. Colon	
		D. Stomach	
		E. Other	

PAST MEDICAL HISTORY

Have you had or are you having any of the following illnesses or disorders? *(check Appropriate Box)*

Heart Problems		Birth Defects	
High Blood Pressure		Arthritis	
Sugar Diabetes		Thyroid Problem	
Overweight		Gout	
Stroke		Anemia	
Chronic Bronchitis		High Cholesterol	
Emphysema (Lung)		Bleeding Problem	
Asthma		Glaucoma (Eyes)	
Tuberculosis		Suicide Attempt	
Hepatitis (Jaundice)		Depression	
Ulcer		Venereal Disease (VD)	
Urinary Stones		Other Disorders of:	
Urinary Infections		Breast	
Seizures (Fits)		Blood Vessels	
Migraine		Stomach	
Decreased Vision		Bowel	
Decreased Hearing		Gallbladder	
Black Lung Problem		Pancreas	
Amputations		Kidneys	

FEMALE HISTORY:

Age of onset of periods: ____________________

Are your periods regular? ____________________

Number of pregnancies: ____________________

Number of miscarriages: ____________________

Age of "Change of Life": ____________________

Do you do self breast exam?