GASTROENTEROLOGY OF WEST CENTRAL OHIO, INC.
DIGESTIVE HEALTH & ENDOSCOPY CENTER, LLC

ABDULLA TAJA, M.D.
SHERI MILLER, MSN, AGNP-C
PRACTICE LOCATIONS:

Main Office	**SidneyOffice**
375 N. Eastown Rd. Lima, OH 45807	915 W. Michigan St. Professional Bldg. Suite 103 Sidney, OH45365

www.gastrowco.com
Phone: (419) 228-3500 Toll Free: 1-877-4DR-TAJA
Fax: (419) 228-6700

How did you hear about us? (Please circle) Doctor referral, Radio, Newspaper, Yellow Pages, Friend, Family, Television

LAST NAME: ____ **FIRST NAME:** ________________________________ **M.I.:** _________

ADDRESS: ____**CITY:**_____________________________ **STATE:** ______ **ZIP:** ___________

HOME PHONE: _________________**CELL PHONE**__________________**WORK PHONE:** __________________ **(Please do not list if you do not want to be contacted at work)**

REFERRING PHYSICIAN: ________________________ **FAMILY PHYSICIAN (If different than referring):** ________________________

PHARMACY NAME: ___________________________**LOCATION:** _____________________ **PHONE:** ____________________________

DATE OF BIRTH: ______________ **AGE:** ________ **MARITAL STATUS: Circle S M D W HEIGHT:** ________ **WEIGHT:**________

SOCIAL SECURITY NUMBER: _________________________**OCCUPATION (Including Prior to retirement):** ________________________

EMPLOYER: ____

SPOUSE / SIGNIFICANT OTHER LAST NAME: ___________________________ **FIRST NAME:** ______________________________

OCCUPATION(Including prior to retirement):__________________________________

EMERGENCY CONTACT (If spouse, please provide an alternate contact number.):

NAME: _________________________________ **RELATIONSHIP:** ________________________ **PHONE:** ______________________

HEALTH INSURANCE: PLEASE BRING CARD(S) AND VALID I.D. TO YOUR APPOINTMENT-WILL NOT BE SEEN WITH OUT I.D.

PRIMARY INSURANCE NAME: ______________________________________ **PRIMARY HOLDER:** ____________________________

PRIMARY HOLDER'S DOB: _______________________**CERTIF/ID#:** __________________________________

GROUP#:__________________________**EMPLOYER:** _______________________________________

SECONDARY INSURANCE NAME: ___________________________________ **PRIMARY HOLDER:** ____________________________

SECONDARY HOLDER'S DOB: ____________________**EMPLOYER:** _______________

CERTIF/ID#: ____________________**GROUP#:** __________________________**INSURANCE PHONE #:** _________________________

I authorize the staff of Gastroenterology of West Central Ohio, Inc. and Digestive Health & Endoscopy Center, LLC (going forward known as "**facilities**") to leave messages confirming upcoming appointments with members of family or by voice message. I hereby authorize the "facilities" to submit a claim to my insurance carrier of its intermediaries for all covered services rendered by the "facilities" and authorize/direct my insurance carrier or its intermediaries to issue payment directly to the physician rendering the required services. I authorize the "facilities" and staff to furnish complete information to my insurance carrier or its intermediaries regarding services required. I understand I am financially responsible for all charges not covered by this authorization. I have read and understand the payment information. I also give permission to the "facilities" to retrieve/use/disclose professional health care information from St. Rita's Medical Center, Lima Memorial Health System, Wilson Memorial Hospitals and other health care hospitals/facilities, Physicians and Pharmacies for treatment, payment and/or health care operations.

Signature____**Date**________________________________

WHAT PROBLEMS BROUGHT YOU IN TODAY?____

HAVE YOU HAD SIGNIFICANT WEIGHT GAIN / LOSS IN THE PAST 6 MONTHS? : ____________________________

PLEASE CIRCLE BELOW ANY ACTIVE PROBLEMS AND UNDERLINE PROBLEMS YOU HAVE BEEN TREATED FOR IN THE PAST:

General: Fever, chills, weight loss, night sweats

Eyes: Cataracts, double vision, glaucoma, pain on exposure to light, loss of vision, macular degeneration.

Ear, Nose, Throat: Hearing loss, sinus infection, nasal polyps, hoarseness, nose bleeds.

Cardiovascular: High blood pressure, high cholesterol or triglyceride, heart disease, heart murmur, angina, chest pains, rheumatic fever,

Respiratory: Pleurisy, TB, coughing up blood, asthma, emphysema, COPD, bronchitis, shortness of breath, chronic cough, sleep apnea.

Gastrointestinal: Difficulty swallowing, heartburn, acid regurgitation, belching, gas, duodenal or gastric ulcer, abdominal pain, liver disease, Jaundice, hepatitis, gallbladder disease, constipation, diarrhea, black stool, blood in stool, change in bowel habits, incontinence (loss of bowel control)

Genitourinary: kidney or bladder infection, blood in urine, kidney stones, nephritis, urinary incontinence, prostate trouble, sexual problems, sexually transmitted disease, extramarital activity, same sex partners.

Gynecologic: (For Women) abnormal bleeding, irregular periods, painful intercourse, frequent pelvic infections, endometriosis, List date of your last period: ________________________________

Musculoskeletal: Painful or swollen joints, arthritis, bone problems, osteoporosis, osteopenia.

Skin and Breast: Rashes, psoriasis, melanoma, tattoos, breast lumps, breast cancer, skin cancer.

Neurological: Frequent headaches, migraines, epilepsy, seizures, passing out of dizzy spells, numbness or tingling of arms or legs, stroke, abnormal movements.

Emotional: **S**exual, physical or emotional abuse, depression, anxiety, excessive nervousness, marital problems, crying spells, suicidal thoughts, in-law problems.

Endocrine: Diabetes, thyroid disease, other gland problems.

Blood: Anemia, bleeding disorder, blood or blood product transfusion.

Allergic/Immunologic: Lupus, HIV (AIDS), other collagen vascular disease, autoimmune disease or immune deficiency.

Cancer: Please list any previous cancers: ____

Do you use Tobacco? _____ What type? _______ How many packs a day? _____ How many years have you used Tobacco? _____
Do you use Alcohol? ____ What type? _______________ How much? __________ Do you use street drugs/type? ____________

Approximate date of last: Physical Exam ___________________ **Sigmoidoscopy** ____________________
(please circle) Echo / Stress Test / Electrocardiogram________________ **Colonoscopy**______________________
Chest X-Ray_____________________ **GI Series** ________________________
Barium Enema____________________ **EGD(upper scope)**_________________
Do you have a history of heart valve problems or need antibiotics before procedure? ______________________________
Please list your heart doctor's name and phone number. ____
List Drug Allergies ____
Do you have a history of allergy of reactions to X-Ray dye or Iodine? ____
Are you sensitive or allergic to latex? ____

List chronologically all operations and all hospitalizations. (Please use separate sheet of paper if needed or back of this one.)

Approx Date	Operation and/or Diagnosis	Hospital	Physician

PLEASE BRING CURRENT MEDICATIONS OR A LIST OF CURRENT MEDICATIONS WITH YOU INCLUDING DOSAGES, Please include Motrin, Advil, Aleve, or all other "pain" meds, herbal medications and supplements, vitamins, laxatives, antacids and birth control pills. (Please use separate sheet of paper if needed or back of this one.)

Medication	Dosage / Strength

PLEASE LIST ALL CURRENT PHYSICIANS

Physician Name	What are they treating you for?

FAMILY HISTORY (Please use separate sheet of paper if needed or back of this one.)

	Age	State of Health and Diagnosis	Age at Death and Cause
Father			
Mother			
Brother or Sister			
Brother or Sister			
Father's Father			
Father's Mother			
Mother's Father			
Mother's Mother			
Spouse			
Son or Daughter			

Does anyone in your family have history of colon polyps? __________ colon cancer?________
If yes, please list how they are related _____________________________What age were they diagnosed? _____________
Does anyone in your family have a history of cancer other than colon?
If yes, please list how they are related and what type of cancer? ____
What age were they diagnosed? _____________

HIPAA PRIVACY AUTHORIZATION FORM

I,_________________________, hereby authorize Gastroenterology of West Central Ohio, Inc. to release information to the following friends and family members regarding my health care.

Name:____________________________Relationship:_________________________

Name:____________________________Relationship:_________________________

Name:____________________________Relationship:_________________________

Name:____________________________Relationship:_________________________

Name:____________________________Relationship:_________________________

☐ Do not discuss/release any of my health care information to anyone but myself.

_______________________________ _________________________

Signature of patient or patient's representative Date

You have the right to receive a copy of our HIPAA privacy statement

<u>*PLEASE KEEP THIS PAGE FOR YOUR RECORDS*</u>

EXCESSIVE CANCELATIONS, LATE RESCHEDULES AND NO SHOW APPOINTMENTS WILL RESULT IN BEING DISCHARGED FROM THE PRACTICE.

<u>PATIENT FEE AND INSURANCE INFORMATION</u>
OUR OFFICE WILL PRE-CERTIFY OUTPATIENT PROCEDURES; HOWEVER, BEFORE YOUR APPOINTMENT PLEASE CHECK WITH YOUR INSURANCE COMPANY REGARDING BENEFITS AND COVERAGE. IF YOU ARE SCHEDULED FOR SCREENING OR PREVENTATIVE SERVICES, PLEASE VERIFY WITH YOUR INSURANCE CARRIER THAT SCREENING OR PREVENTATIVE SERVICES ARE COVERED BENEFITS UNDER YOUR PLAN. SOME INSURANCE COMPANIES MAY NOT COVER THESE TYPES OF SERVICES.

PLEASE BRING YOUR INSURANCE CARDS AND ID TO EACH VISIT WITH OUT YOUR CARDS YOUR APPOINTMENT MAY BE CANCELED. **We Do Not Take Amerigroup Health Ins.**

CO-PAYS ARE DUE AT EACH APPOINTMENT. WE ACCEPT CASH, MAJOR CREDIT CARDS OR CHECKS MADE PAYABLE TO: GASTROENTEROLOGY OF W.C. OHIO INC.
(Return checks are subject to a 30.00 return check fee)

******Follow up visit co-pays do apply after all procedures. They are not included in the procedure price since not all patients require a follow up visit. ******

All prescriptions for controlled substances must be picked up at the office in person. We are not able to mail them or fax them to you or your pharmacy.

****SELF PAY PATIENTS ARE QUALIFIED FOR A SELF PAY DISCOUNT. YOU ARE REQUIRED TO PAY 150.00 AT YOUR FIRST VISIT AND 50.00 AT EACH FOLLOW UP. ANY ADDITIONAL BALANCE WILL BE BILLED TO YOU. IF YOU ARE UNABLE TO PAY THE BALANCE, PAYMENT PLANS MAY BE ESTABLISHED.***

*** Self-Pay patients are required to pay a 200.00 deposit before scheduling a procedure. A 300.00 deposit is required if you are having a colonoscopy and EGD.**

***MISSED APPOINTMENTS ARE SUBJECT TO FEES AS FOLLOWS:**

- **NO SHOW APPOINTMENTS: $25.00**
- **APPOINTMENTS NOT CANCELLED/RESCHEDULED WITH 24 HOURS NOTICE: $25.00**
- **NO SHOW TO PROCEDURES: $100.00**
- **PROCEDURES NOT CANCELLED/RESCHEDULED WITH 24 HOURS NOTICE: $100.00**

(THESE FEES WILL BE BILLED TO THE PATIENT NOT TO THE INSURANCE AND MUST BE PAID TO RESCHEDULE APPOINTMENTS/PROCEDURES.)

<u>PLEASE KEEP THIS PAGE FOR YOUR RECORDS.</u>

Thank you for your time in completing this information. We look forward to assisting you with your medical needs and concerns.

drt 05/15

GASTROENTEROLOGY OF WEST CENTRAL OHIO, INC.
ABDULLA TAJA, M.D.
SHERI MILLER, APRN - NP

PRACTICE LOCATIONS:

Main Office	Sidney Office
375 N. Eastown Rd.	915 W. Michigan St.
Lima, OH 45807	Professional Bldg.
	Suite 103
	Sidney, OH45365

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Statement of Patient Financial Responsibility

Patient Name: ____ DOB: _______________________

Gastroenterology of West Central Ohio appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to The Practice Name, for providing _____________ services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to The Practice Name, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ____ Date ___________________________

Guarantor Signature ____ Date ___________________________
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ____ Date ____________________________