

# WELCOME TO GRAND TETON GASTROENTEROLOGY

Dear Patient,

Thank you for choosing us as your health care provider. We are committed to providing quality medical care to all individuals in need of digestive health services. The following information is to assist you in obtaining the greatest benefit from your visit at the least expense.

## Health History Information

By collecting and providing this information prior to your appointment, you can help us avoid duplicate testing and extra costs. To assist your physician in thoroughly evaluating your health, please:

A: Please fill out the enclosed health history form

B: Collect from your previous physicians all pertinent medical records related to why we are seeing you

1. All lab tests within the last year, all endoscopy reports within the last 10 years such as:  
colonoscopy, upper endoscopy, flex sigs, liver biopsy
2. Any biopsy, pathology, or related gastrointestinal surgery reports
3. Consultation notes from your referring physician or other internal medicine or gastroenterology physicians that you have previously seen.
4. X-ray films and reports that relate to why you are being seen.

To obtain these records, you may contact the appropriate physician's office, or in the case of x-rays, you may bring them in the day of your appointment.

**\*If you do not understand what we are requesting, or if you are not able to comply with our requests, please call our office at (208) 522-4000 so we can assist you.**

## Grand Teton Gastroenterology & Your Insurance

The physicians in our office are specialists who have received extensive training in the specialty of gastroenterology. The fees for the services we provide are established based upon the skills, training, and time required by the physician to complete your consultation and/or procedure. You may expect the charge for your first appointment or for subsequent follow-up visits to be:

New patient consultations: from \$75 to \$440  
Follow up visits: from \$45 to \$225

Any questions concerning procedure costs, please contact Tammy at (208) 528-4252. There is an additional charge for all visits following procedures.

## Referrals/Pre-authorizations

Insurance companies such as DMBA and Medicaid Healthy Connections require referral forms from the primary care physician. If you are receiving assistance from a county program, you will need to obtain prior authorization from them before being seen. Referral forms and pre-authorizations must reach our office prior to your appointment, or we will have to reschedule your appointment.

*This office is a participating provider with Traditional Blue Cross of Idaho, Blue Cross of Idaho PPO, Regence Blue Shield of Idaho, Medicare, Medicaid, CCN, DMBA, IPN, Altius, and SIPHO.*

## **Submission of Insurance Claims**

To assist our billing staff in submitting your insurance claim to both the primary and secondary insurance carrier, we will verify your insurance benefits. Please call Sharol at (208) 528-4241

## **Insurance Payments**

Insurance companies base the amount they will pay off the allowable and on the policy's deductible.

- \* **Allowable:** What the insurance company has established as the dollar amount upon which they base their payment for the service/procedure.
- \* **Deductible:** Your payment responsibility each policy year and/or with different types of services.

The allowances made by your particular insurance company are separate and apart from the fees that we charge. When a company does not allow or pay all of given medical expense, the wording used is often: 'the fee charged exceeds the usual and customary allowance for this procedure.' This means that your policy does not fully pay for the service due to policy limitations- not that the fee is excessive. Our billing department has a history of many allowances from numerous insurance companies. Please contact Tammy at (208) 528-4252 for this information.

Our insurance policies:

- \* Your insurance policy is a contract between you and your insurance company; we are not a party to that contract
- \* If your insurance company has not paid your claim within 45 days, the balance will be due and payable from you.
- \* Insurance payments that you receive directly must be forwarded to Grand Teton Gastroenterology

## **Your involvement**

Grand Teton Gastroenterology will work closely with you to obtain the maximum benefit from your insurance company. While we make every effort to help patients receive their insurance benefits, insurance companies are often more responsive to their customers, the patients. To improve the payment process, our office may ask you to contact your insurance company personally.

## **Our Commitment**

The Grand Teton Gastroenterology is committed to providing quality medical care to all those in need of our services. We will also work with you to establish payment arrangements, or help you find the appropriate medical coverage. You are welcome to contact our office with your questions and concerns.

Sincerely,

Grand Teton Gastroenterology Administrative Staff

Sharol (Accounts Coordinator) 528-4241 Tammy (Insurance Clerk) 528-4252  
Melissa (Billing Assistant Manager) 528-4255

**Grand Teton Gastroenterology**  
2770 Cortez Avenue  
Idaho Falls, ID 83404  
(208) 522-4000

**\*\*\*PLEASE NOTE\*\*\***

~ Your first appointment in the office will be for a **CONSULTATION** only. Any procedures will be scheduled on a later date.

~ Due to the length of our wait list, it is necessary that we charge a no show fee. **This fee is \$50 and there will be NO EXCEPTIONS.** If you cannot make it in for your scheduled appointment, you **MUST** call and cancel your appointment ahead of time!

~ **If the patient is a minor (under the age of 18 years old), he/she MUST be accompanied by a legal guardian for all appointments.** If the minor shows up for an appointment without a guardian, the appointment will have to be rescheduled.

~**We have an electronic reminder system that calls two days before your appointment date. Please take note that the telephone number you enter on your registration form is the number that this system will be contacting (and possibly leaving a message with). If you have any concerns in regards to this, please let us know.**

SUNNYSIDE

EIRMC

Idaho Falls Care Center

DESSO

CHANNING

CORTEZ

Home Oxygen

Home Care Ctr.

Idaho Heart Institut

GRAND TETON SURGICAL CENTER

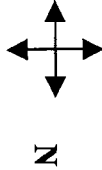
CORONADO

Community Care

GRAND TETON G.I. 2770 Cortez

Eye Center

Mountain View Hosp.



# GRAND TETON GASTROENTEROLOGY, P.A.

## Patient Information:

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Mailing Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Telephone: \_\_\_\_\_ Cell # \_\_\_\_\_

S.S. # \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer: \_\_\_\_\_ Work # \_\_\_\_\_

Spouse's Name OR if minor, Responsible Party's Name \_\_\_\_\_

S.S. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer: \_\_\_\_\_ Work # \_\_\_\_\_

## Primary Insurance Information:

Policy-holder: \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

Phone # \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

## Secondary Insurance Information:

Policy-holder: \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

Phone # \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

## Emergency Contact (nearest relative not living with you)

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Telephone # \_\_\_\_\_ Work # \_\_\_\_\_

**Contract to Pay for Medical Services**

In consideration of professional services rendered to the above patient, I/we agree to pay your customary charges for these services, in full, at the time of service, unless prior arrangements are made with Grand Teton Gastroenterology, P.A. to receive assignment of insurance payments. If the customary chares are more than the benefits allowed under the responsible party's insurance plan, I/we agree to pay the difference. I/we understand I am responsible for payment regardless of any insurance company's determination of usual and customary rates. I/we understand that an interest charge of 1-1/2% per month will be added to accounts over 30 days and that if it becomes necessary to turn this account to collection, collection fees will be charged and I/we will be responsible for the fees.

I also understand that:

- ❖ Grand Teton Gastroenterology, P.A. is a participation office with Medicare, therefore, no payment will be requested at time of service.
- ❖ All deductibles and co-pays are due at the time of service.
- ❖ If my insurance company has not paid my claim within 45 days, I am responsible for the balance.
- ❖ I may pay by cash, check, debit card, or major credit card.
- ❖ My balance is due and payable once the insurance pays.
- ❖ **An office visit is necessary within 30 days prior to any of the following procedures: liver biopsy colonoscopy, upper endoscopy or ERCP.**

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**Patient or Responsible Party's Signature**

**Date**

**Authorization to release information**

The Grand Teton Gastroenterology, P.A. is hereby authorized to release and/or request any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

The following **family members** are authorized to receive my medical information:

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**Patient or Responsible Party's Signature**

**Date**

## GRAND TETON GASTROENTEROLOGY MEDICAL & FAMILY HISTORY FORM

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

**Allergies**

- |                               |                               |                                |                                  |                              |             |
|-------------------------------|-------------------------------|--------------------------------|----------------------------------|------------------------------|-------------|
| <input type="radio"/> None    | <input type="radio"/> Demerol | <input type="radio"/> Latex    | <input type="radio"/> Penicillin | <input type="radio"/> Valium | Other _____ |
| <input type="radio"/> Aspirin | <input type="radio"/> Iodine  | <input type="radio"/> Morphine | <input type="radio"/> Sulfa      | <input type="radio"/> Versed |             |

**Past or Present Medical Problems**

- |  |                                      |  |  |   |
|--|--------------------------------------|--|--|---|
| <input type="radio"/> None                 | <input type="radio"/> Depression     | <input type="radio"/> Heart Murmur         | <input type="radio"/> Kidney Stones      | <input type="radio"/> Psoriasis             |
| <input type="radio"/> Anemia               | <input type="radio"/> Diabetes I     | <input type="radio"/> Hepatitis            | <input type="radio"/> Lupus              | <input type="radio"/> Reflux or GERD        |
| <input type="radio"/> Arthritis            | <input type="radio"/> Diabetes II    | <input type="radio"/> Hiatal Hernia        | <input type="radio"/> Migraines          | <input type="radio"/> Rheumatic Fever       |
| <input type="radio"/> Asthma               | <input type="radio"/> Diverticulitis | <input type="radio"/> High Cholesterol     | <input type="radio"/> Milk Tolerance     | <input type="radio"/> Seizures              |
| <input type="radio"/> Cancer               | <input type="radio"/> Duodenal Ulcer | <input type="radio"/> High Triglycerides   | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Stomach Ulcer         |
| <input type="radio"/> Cataracts            | <input type="radio"/> Ear Infections | <input type="radio"/> HIV/ AIDS            | <input type="radio"/> Osteoporosis       | <input type="radio"/> Stroke                |
| <input type="radio"/> Celiac Disease       | <input type="radio"/> Emphysema      | <input type="radio"/> Hypertension         | <input type="radio"/> Ovarian Cyst       | <input type="radio"/> TB Skin Test Positive |
| <input type="radio"/> Chronic Anxiety      | <input type="radio"/> Fatty Liver    | <input type="radio"/> Insulin Resistance   | <input type="radio"/> Pancreatitis       | <input type="radio"/> TB Tuberculosis       |
| <input type="radio"/> Chronic Cough        | <input type="radio"/> Gall Stones    | <input type="radio"/> Iritis               | <input type="radio"/> Paralysis          | <input type="radio"/> Thyroid Disease       |
| <input type="radio"/> Chronic Lung Disease | <input type="radio"/> Glaucoma       | <input type="radio"/> Irregular Heart Beat | <input type="radio"/> Parkinson's        | <input type="radio"/> Ulcerative Colitis    |
| <input type="radio"/> Chronic Sinusitis    | <input type="radio"/> Gonorrhea      | <input type="radio"/> Irritable Bowel      | <input type="radio"/> Peptic Ulcer       | <input type="radio"/> Other _____           |
| <input type="radio"/> Cirrhosis of Liver   | <input type="radio"/> Gout           | <input type="radio"/> Kidney Disease       | <input type="radio"/> Phlebitis          | <input type="radio"/> Other _____           |
| <input type="radio"/> Colon Polyps         | <input type="radio"/> Groin Hernia   | <input type="radio"/> Kidney Failure       | <input type="radio"/> Pnuemonia          | <input type="radio"/> Other _____           |
| <input type="radio"/> Crohn's Disease      | <input type="radio"/> Heart Attack   | <input type="radio"/> Kidney Infection     | <input type="radio"/> Polio              | <input type="radio"/> Other _____           |

**Surgeries/Hospitalizations/Procedures**

- |  |   |                                     |   |                                       |
|--|---|-------------------------------------|---|---------------------------------------|
| <input type="radio"/> None             | <input type="radio"/> Cardiac Valve Replacement | <input type="radio"/> ERCP          | <input type="radio"/> Hysterectomy      | <input type="radio"/> Obesity Surgery |
| <input type="radio"/> Appendectomy     | <input type="radio"/> Cholecystectomy           | <input type="radio"/> Gallbladder   | <input type="radio"/> Joint Replacement | <input type="radio"/> Tonsillectomy   |
| <input type="radio"/> Cardiac Bypass   | <input type="radio"/> Colonoscopy               | <input type="radio"/> Heart surgery | <input type="radio"/> Kidney            | <input type="radio"/> TURP            |
| <input type="radio"/> Cardiac Stenting | <input type="radio"/> EGD                       | <input type="radio"/> Hernia        | <input type="radio"/> Liver Biopsy      | <input type="radio"/> Other _____     |

**Social History Marital Status:**

- Single     Separated     Married  
 Divorced     Widowed

**Social History Alcohol:**

- Never                       More than 2 days per week  
 Rarely                       Less than 2 days per week  
 Daily                         I quit using alcohol

**Number of Children**

- 0    1    2    3    4    5    6+    none

**Social History Tobacco:**

- I use tobacco products  
 I quit using tobacco products  
 I have never used tobacco products

**Social History Occupation:**

Patient Occupation \_\_\_\_\_  Veteran

## REVIEW OF SYSTEMS

### Gastrointestinal:

- |  |   |  |   |                                   |
|--|---|--|---|-----------------------------------|
| <input type="radio"/> None               | <input type="radio"/> Blood in Stool                | <input type="radio"/> Excessive Flatulence | <input type="radio"/> Nausea                  | <input type="radio"/> Other _____ |
| <input type="radio"/> Abdominal pain     | <input type="radio"/> Change in Bowel Habits        | <input type="radio"/> Fat Intolerance      | <input type="radio"/> Poor Appetite           | <input type="radio"/> Other _____ |
| <input type="radio"/> Belching           | <input type="radio"/> Constipation                  | <input type="radio"/> Heartburn            | <input type="radio"/> Rectal Bleeding         | <input type="radio"/> Other _____ |
| <input type="radio"/> Black Tarry Stools | <input type="radio"/> Diarrhea                      | <input type="radio"/> Hemorrhoids          | <input type="radio"/> Soiling or Incontinence | <input type="radio"/> Other _____ |
| <input type="radio"/> Bloating           | <input type="radio"/> Difficulty Swallowing Liquids | <input type="radio"/> Jaundice             | <input type="radio"/> Vomiting                | <input type="radio"/> Other _____ |

### Genitourinary:

- |   |                                   |
|---|-----------------------------------|
| <input type="radio"/> None                        | <input type="radio"/> Other _____ |
| <input type="radio"/> Change in urinary frequency |                                   |
| <input type="radio"/> Blood in urine              |                                   |
| <input type="radio"/> Difficulty with Urination   |                                   |
| <input type="radio"/> Sexual difficulty           |                                   |

### Skin:

- |                               |                                      |
|-------------------------------|--------------------------------------|
| <input type="radio"/> None    | <input type="radio"/> Skin Infection |
| <input type="radio"/> Nodules | <input type="radio"/> Tattoos        |
| <input type="radio"/> Rashes  | <input type="radio"/> Other _____    |

### Cardiovascular:

- |  |   |   |
|--|---|---|
| <input type="radio"/> None                             | <input type="radio"/> Irregular Heart Beat      | <input type="radio"/> Shortness in breath with exertion |
| <input type="radio"/> Angina/Chest Pressure w/activity | <input type="radio"/> Pain in legs when walking | <input type="radio"/> Swelling in legs                  |
| <input type="radio"/> Enlarged Heart                   | <input type="radio"/> Rapid Heart Rate          | <input type="radio"/> Varicose veins                    |
|  |   | <input type="radio"/> Other _____                       |

### Neurological:

- |  |   |
|--|---|
| <input type="radio"/> None                       | <input type="radio"/> Restless Leg Syndrome |
| <input type="radio"/> Chronic numbness/ tingling | <input type="radio"/> Weakness in arms      |
| <input type="radio"/> Dizziness/ lightheadedness | <input type="radio"/> Weakness in legs      |
| <input type="radio"/> Frequent Headaches         | <input type="radio"/> Other _____           |

### Endocrine:

- |  |  |
|--|--|
| <input type="radio"/> None                       | <input type="radio"/> Excessive Thirst |
| <input type="radio"/> Abnormal Hair Growth       | <input type="radio"/> Goiter           |
| <input type="radio"/> Abnormal Hair Loss         | <input type="radio"/> Hot Flashes      |
| <input type="radio"/> Abnormal Hot or Cold       | <input type="radio"/> Other _____      |
| <input type="radio"/> Breast Enlargement or Pain |  |

### Constitutional:

- |                               |                                    |
|-------------------------------|------------------------------------|
| <input type="radio"/> None    | <input type="radio"/> Night Sweats |
| <input type="radio"/> Chills  | <input type="radio"/> Weight Gain  |
| <input type="radio"/> Fatigue | <input type="radio"/> Weight Loss  |
| <input type="radio"/> Fever   | <input type="radio"/> Other _____  |

### Psychiatric:

- |                                      |  |
|--------------------------------------|--|
| <input type="radio"/> None           | <input type="radio"/> Emotional Problems |
| <input type="radio"/> Abnormal Sleep | <input type="radio"/> Memory Loss        |
| <input type="radio"/> Anxiety        | <input type="radio"/> Nervous breakdown  |
| <input type="radio"/> Confusion      | <input type="radio"/> Other _____        |

### Eyes:

- |  |                                    |
|--|------------------------------------|
| <input type="radio"/> None             | <input type="radio"/> Inflammation |
| <input type="radio"/> Blindness        | <input type="radio"/> Poor Vision  |
| <input type="radio"/> Change in Vision | <input type="radio"/> Other _____  |

### Hematologic:

- |   |   |
|---|---|
| <input type="radio"/> None                          | <input type="radio"/> Taking Blood Thinners     |
| <input type="radio"/> Bleeding does not stop easily | <input type="radio"/> Thrombosis or Blood Clots |
| <input type="radio"/> Enlarged Glands               | <input type="radio"/> Transfusions              |
| <input type="radio"/> Frequent Bleeding             | <input type="radio"/> Other _____               |

### Ears, Nose and Throat:

- |   |                                       |
|---|---------------------------------------|
| <input type="radio"/> None                    | <input type="radio"/> Hoarseness      |
| <input type="radio"/> Bleeding Gums           | <input type="radio"/> Mouth Sores     |
| <input type="radio"/> Chronic sinus           | <input type="radio"/> Nose Bleeds     |
| <input type="radio"/> Corrective Lenses       | <input type="radio"/> Ringing in Ears |
| <input type="radio"/> Frequent Ear Infections | <input type="radio"/> Tinnitus        |
| <input type="radio"/> Hearing Loss            | <input type="radio"/> Other _____     |

### Musculoskeletal:

- |  |                                      |
|--|--------------------------------------|
| <input type="radio"/> None                 | <input type="radio"/> Swollen joints |
| <input type="radio"/> Back Pain            | <input type="radio"/> Other _____    |
| <input type="radio"/> Chronic Stiff Joints |                                      |

### Respiratory:

- |                                      |                                    |
|--------------------------------------|------------------------------------|
| <input type="radio"/> None           | <input type="radio"/> Inflammation |
| <input type="radio"/> Chronic Cough  | <input type="radio"/> Poor Vision  |
| <input type="radio"/> Cough up Blood | <input type="radio"/> Other _____  |

### Immunologic:

- |                                   |                                   |
|-----------------------------------|-----------------------------------|
| <input type="radio"/> None        | <input type="radio"/> HPV         |
| <input type="radio"/> Flu         | <input type="radio"/> Pneumonia   |
| <input type="radio"/> Hepatitis A | <input type="radio"/> Other _____ |
| <input type="radio"/> Hepatitis B |                                   |





## MEDICAL RECORDS RELEASE FORM

I hereby authorize **Grand Teton Gastroenterology** to obtain/receive the

following information from the facility of \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_ Patient Number: \_\_\_\_\_

**Covering the period(s) of healthcare:**

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

**Information to be disclosed:**

Complete health records  
History and Physical exam  
Progress Notes  
Radiology Notes

Discharge summary  
Consultation reports  
Laboratory Tests  
Other (please specify)  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Or (Legal Representative)