

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

Please note that if a procedure is scheduled with one of our physicians, a deposit amount will be required from the patient. This amount will be applied to the physician portion of your procedure.

If you have any other questions concerning procedure costs, please contact Melissa at 528-4255. There is an additional charge for all visits following procedures.

Referrals

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.

Pre-authorizations for Procedures

Procedures that are scheduled with one of our physicians may require a pre-authorization in order for the insurance company to pay the charge. Pre-authorizations are the patient's responsibility, and our office will assist you with the appropriate instructions that you will need to do this.

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 Kami 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 our **Main Billing Department at 1-800-343-7577.**

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

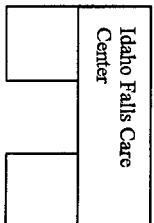
Main Billing Department: 1-800-343-7577

Kami (Accounts Coordinator): (208) 528-4241 • Melissa (Billing Coordinator): (208) 528-4255

SUNNY-SIDE

EIRMC

Idaho Falls Care Center



DWIGHT

CHANNING

CORTEZ

Home Oxygen

Home Care Ctr.

Idaho Heart Institut

GRAND TETON SURGICAL CENTER

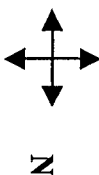
CORONADO

Community Care

GRAND TETON G.I. 2770 Cortez

Eye Center

Mountain View Hosp.



Grand Teton Gastroenterology

2770 Cortez Avenue

Idaho Falls, ID 83404

Phone: (208) 522-4000

Fax: (208) 528-4242

*****PLEASE NOTE*****

- Make sure to bring your ID/driver's license and insurance card(s) to your scheduled appointment**
- All copays and deductibles are required at the time of service**
- There will be a deposit amount required for any procedures that are scheduled with one of our physicians**
- Due to the length of our wait list, it is necessary that we charge a \$50 no show fee to patients who do not show up for their scheduled appointment. 24 hours is mandatory for an appointment cancellation.**
- As a courtesy, our electronic reminder system will call you 2 business days before your appointment date. The primary phone number you enter on your form will be the number that is contacted for your courtesy reminder call.**

GRAND TETON GASTROENTEROLOGY, P.A.

Patient Information:

Name: _____
(First) (Middle) (Last)

Mailing Address: _____
(Street) (City) (State) (Zip)

Primary Telephone: _____ Cell/Other: _____

S.S. #: _____ Sex: ____ Date of Birth: _____ Marital Status: _____

Employer: _____ Work Phone: _____

Referring Physician or Primary Care Provider: _____

Spouse's Name OR if Minor, Name of Responsible Party: _____

Birthdate: _____ S.S. #: _____ Relationship: _____

Employer: _____ Work Phone: _____

Primary Insurance Information:

*Policy-holder: _____ *Date of Birth: _____ Relationship: _____

*Insurance Company: _____ (please provide card to receptionist)

ID#: _____ Group #: _____ Phone #: _____

Secondary Insurance Information:

*Policy-holder: _____ *Date of Birth: _____ Relationship: _____

*Insurance Company: _____ (*please provide card to receptionist*)

ID#: _____ Group #: _____ Phone #: _____

Emergency Contact (nearest relative or friend who is not living with you):

Name: _____ Relationship: _____

Mailing Address: _____
(Street) (City) (State) (Zip)

Primary Telephone: _____ Cell/Other: _____

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 have been made with Grand Teton Gastroenterology, P.A. to receive assignment of insurance payments. If the customary charges are more than the benefits allowed under the responsible party's insurance plan, I/we agree to pay the difference. I/we understand that 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 1.5% per month will be added to accounts with balances over 30 days. If it becomes necessary to turn this account to collection, I/we understand that collection fees will be charged and I/we will be responsible for these fees.

I also understand that:

- ❖ Grand Teton Gastroenterology, P.A. is a participation office with Medicare; therefore no payment will be requested at the time of service
- ❖ All deductibles and copays are due at the time of service and will be collected prior to your office visit- **cash, checks, and major credit cards accepted**
- ❖ If my insurance company has not paid my claim within 45 days, I am responsible for the balance
- ❖ My balance is due and payable once the insurance company pays
- ❖ An office visit is necessary within 30 days prior to most of the following procedures:
Liver biopsy, Colonoscopy, Upper Endoscopy or ERCP
- ❖ A \$50 no show fee will be charged to my account for any missed appointments unless I notify Grand Teton Gastroenterology of cancellation at least 24 hours prior to my scheduled appointment.
- ❖ When scheduling a procedure, there is a \$200 deposit that is required at the time of scheduling. This deposit will be applied toward the physician's fee that is charged.

X _____
 Patient or Responsible Party's Signature Date

Authorization to Release Information

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 persons are authorized per my consent to receive or discuss my medical information:

 (Name) (Relationship)

 (Name) (Relationship)

 (Name) (Relationship)

X _____
 Patient or Responsible Party's Signature Date

- | | | | | |
|----------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Hypertension, unspecified | <input type="checkbox"/> Insulin Resistance | <input type="checkbox"/> Irritable bowel syndrome (IBS) | <input type="checkbox"/> Kidney disease, chronic | <input type="checkbox"/> Lactose Intolerance |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Peptic ulcer disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> TB Skin Positive Test | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Autoimmune Hepatitis | <input type="checkbox"/> Barrett's Esophagus |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> H. Pylori | <input type="checkbox"/> Iron Deficiency | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Implanted Defibrillator (AICD) |
| <input type="checkbox"/> Sleep apnea | Other: _____ | Other: _____ | Other: _____ | Other: _____ |

Previous Procedures

- | | | | | |
|---------------------------------------|------------------------------------------|-------------------------------------------|----------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> None | | | | |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiac Bypass | <input type="checkbox"/> Cardiac Stenting | <input type="checkbox"/> Cardiac Valve Replacement | <input type="checkbox"/> Cholecystectomy |
| <input type="checkbox"/> EGD | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> ERCP | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Gastric By-Pass | | | |

Social History

Occupation: _____ Number of Children: _____

Marital Status

- Single
 Married
 Divorced
 Widowed
 Other

Alcohol

- None

Type	Quantity	Frequency
_____	_____	_____

Tobacco

- Smoking Status**
 Current every day smoker
 Current some day smoker
 Former smoker
 Never smoker
 Smoker, current status unknown
 Unknown if ever smoked

Family Medical History

- No knowledge of family history

No family history of Colon cancer Polyps

Health Status

	Mother	Father	Sister	Brother	Daughter	Son	Grandfather	Grandmother
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased/At Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism in family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cancer

Colon polyps

Colitis

Colon Cancer

Crohn's Disease

Heart Trouble

Liver Disease

Stomach Cancer

Ulcer Disease

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Review Of Systems

<p>Allergic/Immunologic <input type="radio"/> None persistent infections strong allergic reactions or urticaria</p> <p>Cardiovascular <input type="radio"/> None chest pain dyspnea with exercise irregular heart beat orthopnea palpitations peripheral edema syncope</p> <p>Constitutional <input type="radio"/> None fatigue fever loss of appetite malaise sweats weight gain weight loss</p> <p>ENMT <input type="radio"/> None dizziness difficulty swallowing double vision ear pain loss of vision nasal obstruction nose bleeds photophobia sore throat</p> <p>Endocrine <input type="radio"/> None excessive thirst hair loss heat intolerance</p>	<p>Gastrointestinal <input type="radio"/> None abdominal pain abdominal swelling change in bowel habits constipation diarrhea gas heartburn jaundice nausea vomiting rectal bleeding black tarry stools stomach cramps difficulty swallowing painful swallowing</p> <p>Genitourinary <input type="radio"/> None dark urine decrease in urine flow dysuria frequent urinary infections frequent urination hematuria impotence nocturia urethral discharge or incontinence</p> <p>Hematologic/Lymphatic <input type="radio"/> None bleeding gums or palpable lymph nodes easy bruising prolonged bleeding</p> <p>Integumentary <input type="radio"/> None allergies dryness hives itching jaundice lesions rashes</p>	<p>Musculoskeletal <input type="radio"/> None arthritis back pain gout joint deformity joint pain muscle weakness stiffness</p> <p>Neurological <input type="radio"/> None dizziness fainting frequent headaches migraine numbness or tingling seizures tremors vertigo</p> <p>Psychiatric <input type="radio"/> None anxiety depression difficulty sleeping hallucinations nervousness panic attacks paranoia</p> <p>Respiratory <input type="radio"/> None asthma cough dyspnea excessive sputum hemoptysis shortness of breath with exercise wheezing</p>
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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)

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
RECORDS RELEASE FORM**

(1) I hereby authorize **Grand Teton Gastroenterology** to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
Address: _____ Telephone: _____
_____ Patient Number: _____

Covering the period(s) of healthcare:

From (date) _____ to (date) _____
From (date) _____ to (date) _____

(2) Information to be disclosed:

Complete health records	Discharge summary
History and Physical exam	Consultation reports
Progress Notes	Laboratory Tests
Radiology notes	Other (please specify)

I understand that these records may include information relating to:

AIDS or HIV
Psychiatric care
Treatment for alcohol and/or drug abuse

(3) This information is to be disclosed to _____
for the purpose of _____.

(4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

(5) The facility, its employees, officers, and physicians are hereby released from any legal responsibility of liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ Date _____
(Patient)

_____ Date _____
or (Legal Representative)