Nashville Gastro Consulting, PLI
William F. Alexander, M.D.

343 22nd Avenue North, Nashville, TN 37203
Ph. 615.327.7835 Fax 615.321.4146

Dear Patient:

We appreciate the opportunity to assist you with your gastroenterology needs. You will find that we make every effort to respond to you and the other members of your health care team in the most efficient manner possible.

In order for us to 1) provide you with the best care possible, 2) communicate with your referring or primary care physician, and 3) file accurate and timely insurance claims, we need for you to fill out the enclosed forms and return them to us as soon as possible.

Since some insurance carriers require referrals from your primary care physician and some procedures and/or medications require prior authorizations, it is important that the information we have for you is accurate and complete. So please enclose a copy of both the front and back of your insurance card(s) when mailing this packet back to us. Also, be sure to always bring your card(s) with you to office visits or procedures. Co-payments are collected before services are rendered; we accept cash, checks, and credit cards.

Two Release of Information forms are included in the packet. One is for our office to receive the records that will help us understand your case history. The other is for us to release records we have created here to any person or entity you designate.

We take pride in providing exceptional digestive care under the highest standards of patient safety and competent medical care in a clean, safe, and comfortable environment. We look forward to making a positive difference in your health.

Sincerely,

Dr. William F. Alexander
And Staff

Patient Information
for Dr. William F. Alexander

Date____________

Patient Name: First______________________MI______Last__________________________

DOB: ______/______/__________ M ____ F ____ SSN______________________________

Address:____Apt:____________________

City:__________________________________ State:___________ Zip:_________________

Hm (_____)______-__________ Cell (_____)______-__________Wk(_____)______-__________

In Case of Emergency Contact:___________________________Relationship:_______________

Phone #:__________________________ Alternate Phone #:___________________________

Pharmacy Name: _____________________________ Phone: ___________________________

(Circle one) Primary Care Physician / Referring Doctor Information:

Name______________________Phone____________________Fax____________________

PracticeName___________________________Address______________________________

City:______________________________ State:__________ Zip:____________________

Insurance Information
If policy holder name is different from patient name please provide policy holder information:

Name:___________________________ **Relationship to patient:**_______________________

Date of Birth:__________________________ **SSN:**________________________________

Address (if different from patient)____
Does your insurance plan require a referral to see a specialist? Yes ____ No ____
Referral Number: ______________ No. of visits authorized _____ Expiration Date __________
Does your insurance plan require pre-authorization for procedures? Yes ____ No ____
Phone# for Pre-Authorization______________________________

Primary **Ins:**________________________Address________________________________

ID#:___________________________Group Name/No:___________________________
Plan Type:_______________________**Co-Pay for Office Visit or Specialist:**_____________

Secondary:______________________Address________________________________

ID#___________________________Group Name/No:___________________________
Plan Type:_______________________**Co-Pay for Office Visit or Specialist:**_____________

NASHVILLE GASTRO CONSULTING, PLLC
HISTORY AND PHYSICAL / CONSULT

Date:________________

LAST NAME	FIRST	NAME YOU PREFER	MIDDLE INITIAL	SEX: M __ F __	AGE	DATE OF BIRTH:
Occupation: ________________ Retired: Y/N	# Dependents_____ WT ____ HT _____	Marital Status: S__ M___ D___ W__	Stress Level on Job: Score 0-10: ________ Level of personal/family stress: Score 0-10:________			

REFERRAL SOURCE: Physician: ________________________________ Other Source:________________________________

Other Doctors You See: ____

LIST ALLERGIES TO MEDICATIONS (NAME OF MEDICATION AND REACTION):
1. ________________________ 2. ________________________ 3. ________________________________

CHIEF COMPLAINT: What is the main reason you are here today?____

Have you had any recent x-rays pertaining to the reason you are here today? Yes ____ No _____ If yes, please explain
Have you had any recent lab tests pertaining to the reason you are here today? Yes ____ No _____ If yes, please explain

PRESENT ILLNESS:
Symptom: ____
Onset: ____
Location: ____
Severity: ____
Timing: ____
What Makes Better: ________________________ WORSE: ________________________________

PRESENT MEDICAL ILLNESSES: Do you have a problem with any of these now? Please answer all questions.

	YES	NO	COMMENTS		YES	NO	COMMENTS		YES	NO	COMMENTS
Heartburn				Diarrhea				Weight Loss			# of pounds _____
Difficulty swallowing			Solids__ Liquids___ Both__	Abdominal Pain				Change in BMs (frequency/color)			
Yellow Skin				Constipation				Fever			
Nausea				Vomiting				Loss of appetite			
Rectal bleeding				Black, Tarry Stools				Do any foods worsen symptoms			
Vomiting blood			How often? ______	Anal Pain with BMs				Bloating/Excessive Gas			

PAST MEDICAL HISTORY: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THE APPROPRIATE BOX.

	Yes	No		Yes	No		Yes	No
blood transfusions			chest pain			free bleeder, i.e. hemophilia		
heart disease			diabetes			kidney problems		
breathing problems			ulcers			sleep apnea		
asthma			liver problems			high blood pressure		
seizure disorder			hepatitis			cancer (if yes, list)		
damaged/replaced heart valve			mitral valve prolapse			rheumatic fever		

PAST SURGICAL HISTORY: SURGICAL ILLNESSES
Have you ever had any surgeries? **YES/NO** **IF YES, PLEASE LIST SURGERY OR PROCEDURE BELOW AND SPECIFY YEAR DONE:**

____
____
____

Are your immunizations up-to-date? (Tetanus, hepatitis B, flu, pneumonia) **YES/NO**

SOCIAL HISTORY - Do you use any of the following?
Alcohol **YES/NO** amount per week: ________________________
Cigarettes **YES/NO** pkg/day or amount: ________________________

Caffeine/Cola **YES/NO** cups/day:________________________
Drug Use (marijuana, etc.) **YES/NO** Type: ________________________
Have you traveled outside the U.S. in the past year? Where: ____________

FAMILY MEDICAL PROBLEMS/CAUSES OF DEATH:
Mother: ______________________ **Brother/Sisters:** ______________________
Father: ______________________ **Children:** ______________________

FAMILY MEDICAL HISTORY Immediate family refers to blood relatives only, not relatives by marriage. This does NOT apply to YOU.

DISEASE	YES	NO	WHO	DISEASE	YES	NO	WHO	DISEASE	YES	NO	WHO
Liver disease				Spastic colon (irritable bowel)				Colon polyps			
Stroke				Anesthesia Complications				Crohn's Disease			
Ulcers				Colon Cancer				Ulcerative Colitis			
Diabetes				Tuberculosis				Cancer			
Asthma											

PLEASE LIST MEDICINES AND DOSAGES YOU ARE TAKING, PLEASE INCLUDE OVER-THE-COUNTER MEDS, HERBS, VITAMINS, ETC.

1.____________	4.____________	7.____________
2.____________	5.____________	8.____________
3.____________	6.____________	9.____________

ANTI-INFLAMMATORY DRUGS: In the last month, have you taken aspirin or aspirin-like drugs such as ibuprofen, Nuprin, Advil, Aleve, BC powders, Goody's powders, Alka- Seltzer, or Anacin? If yes, circle the drug. Others:______________________

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK THE APPROPRIATE BOX.

REVIEW OF SYSTEMS	YES	NO	REVIEW OF SYSTEMS	YES	NO	REVIEW OF SYSTEMS	YES	NO	REVIEW OF SYSTEMS	YES	NO
Change in weight			Sore throat			Difficulty swallowing			Arm/leg weakness		
Fatigue			Shortness of breath			Rectal bleeding			Arthritis/back pain		
Skin changes			Asthma			Nausea			Anemia/blood disorder		
Rash			High cholesterol			Food allergies			Thyroid problems		
Frequent headaches			High blood pressure			Bowel incontinence			Nervousness/depression		
Hoarseness			Vomiting			Blood in urine					

PHYSICAL EXAM (TO BE COMPLETED BY PHYSICIAN)

CONSTITUTIONAL	VS: WT: ________ R: ______ P: ______ BP: __________ Temp:	WNL	ND	COMMENTS
GENERAL	NAD; WDWN.			
EYES	Sclerae anicteric. PERRLA.			
NECK	Without masses. Thyroid symmetric. Non-enlarged.			
RESPIRATORY	Respiratory effort is normal. Breath sounds clear to auscultation.			
CV	Heart RRR. No murmurs, rubs, or gallops.			
ABDOMEN	Soft, no tenderness to palpation, no hsm, no guarding, no rebound, no masses, no inguinal hernias.			
RECTAL	No fissures/fistulas, no external hemorrhoids, no hemorrhoidal tags, heme negative			
LYMPH	No neck, supraclavicular, axillae, groin nodes palpable. No nodal tenderness.			
SKIN	No rash, lesions, jaundice			
PSYCHIATRIC	Normal orientation, memory. (Mood/ Depression)			
MUSCULO-SKELETAL	Normal gait. Strength is equal. Normal range of motion.			
NEUROLOGIC	Cranial nerves II-XII grossly intact. Normal sensation/reflexes.			

Labs Reviewed: ______________________ Old Records Reviewed: Yes/No. Time Spent Counseling __________

Anesthesia Class of Physical Status:__ Class I: No systemic illness. ____ Class II: Mild to moderately severe systemic illness. ____ Class III: Severe systemic illness. ____ Class IV: Life-threatening illness. ____ Class V: Moribund patient. **Anesthesia Plan:** Patient will be sedated with a benzodiazepine and a narcotic such that protective reflexes are maintained. A preoperative oral dose of a barbiturate may be given. **Informed Consent:** The nature, alternatives, indications, risks, and plan for conscious sedation and the above procedure(s) were discussed with the patient and/or guardian and questions were answered. The patient and/or guardian verbalized an understanding and agreed to undergo the procedure.

M.D. Signature:______________________ **Date:**______________________

Nashville
Gastro Consulting, PLLC

ASSIGNMENT OF BENEFITS

I hereby assign medical benefits due to me to be paid directly to Nashville Gastro Consulting, PLLC. I hereby consent to the release of medical records when, necessary for billing and reimbursement. I understand that a photocopy of this release is as valid as the original.

Signature:__________________________________ **Date:**______________

Financial Policy

It is our policy to bill your insurance carrier as a courtesy. Arrangements for your deductible should be made today. If within 90 days your insurance has not remitted payment on your account, the balance is due in full from you. Excessive payments will be promptly refunded. You recognize an obligation to forward to Nashville Gastro Consulting, PLLC any payment received by you, but due to us.

If collection efforts must be pursued, you will be held responsible for the collection agency and/or attorney fees.

The above does not apply to those patients considered to be covered under workman compensation. However, be advised that you will be held responsible for your account in the event your claim is controverted. I have read the above. I agree with and understand its contents.

Signature:__________________________________ **Date:**______________

New Patient Consent to the use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, ________________, understand that as part of my health care, Nashville Gastro Consulting Clinic, PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Nashville Gastro Consulting Clinic, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Nashville Gastro Consulting Clinic, PLLC reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Nashville Gastro Consulting Clinic, PLLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept or decline the terms of this consent (circle one).

____
Patient's Signature

____
Date

FOR OFFICE USE ONLY
[ ] Consent received by ________________ on ________________.
[ ]Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on ________________.

Nashville Gastro Consulting, PLLC
William F. Alexander, M.D.

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Setting the standards for exceptional digestive care

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ______________________________

Date of Birth: ______________________________

Social Security#: ______________________________

I request and authorize **NASHVILLE GASTRO CONSULTING, PLLC** to release my medical records to:

____

____

____

This request and authorization applies to:

__________________________ Health Care Information relating to the following
(Patient Name)

treatment, condition or dates of Treatment: ____________________
(if applicable)

__________________________ All health care information

__________________________ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

__________________________ __________________
Signature of Patient (or Patient's Authorized Representative) Date

__________________________ __________________
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.) Date

NGC TO RELEASE RECORDS

Nashville Gastro Consulting, PLLC
William F. Alexander, M.D.

343 22nd Avenue North, Nashville, TN 37203
Ph. 615.327.7835 Fax 615.321.4146

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ______________________________

Date of Birth: ______________________________

Social Security#: ______________________________

I request and authorize ______________________________ to release my medical records to:

Dr. William F. Alexander -- Nashville Gastro Consulting, PLLC
343 22nd Ave., N.
Nashville, TN 37203
FAX – 615-321-4146

This request and authorization applies to:

______________________________ Health Care Information relating to the following
(Patient Name)
treatment, condition or dates of Treatment: ______________________________
(if applicable)

______________________________ All health care information

______________________________ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

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Signature of Patient (or Patient's Authorized Representative) Date

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Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.) Date

NGC TO RECEIVE RECORDS