Winchester Gastroenterology Associates
540.667.1244
WinchesterGastro.com

NEW PATIENT PRACTICE INFORMATION

Welcome and thank you for choosing Winchester Gastroenterology Associates! We look forward to providing you with the very best care. Before you meet with your provider, we ask that you review, complete, and sign the following forms:

- ☐ Patient Financial Responsibility form
- ☐ Notice of Privacy Practices (for your review only)
- ☐ Acknowledgement of Receipt of Notice of Privacy Practices – Authorization for Release of Medical Records
- ☐ Patient & Insurance Information form
- ☐ Medical History form

These forms are available on our website at **WinchesterGastro.com/Forms**

We work hard to see our patients in a timely manner, so it is important for your care that these forms are completed prior to your appointment time.

As a new patient to us, we ask that you **arrive 20 minutes prior to your scheduled appointment time.** Patients who arrive 10 minutes past their scheduled appointment time may be asked to reschedule.

Office Hours:
Our regular office hours are Monday through Friday, 7:30 AM – 4:00 PM. The office is closed on all major holidays.

Directions to our office:
We are located on the Winchester Medical Center campus, Medical Office Building II (MOB II), Suite 300 (3rd Floor). When you step out of the elevators, our entry is on your immediate right. Please contact us should you need further assistance with directions.

Parking is available in the purple lot in front of the building, but spaces are limited. There is free parking in the garage. Garage #1 is closest to our building. Please take this into consideration so you may arrive 20 minutes before your scheduled appointment time.

Please bring with you:

- ☐ Insurance cards and personal identification
- ☐ Completed New Patient paperwork (listed above)
- ☐ Medication list. **Please ensure the list is current. Do not bring your medication bottles.**
- ☐ Any medical records that would be important to your office visit, including test results. Please contact your referring provider to have your medical records sent to our office. Our fax # is (540) 662-1187.

If you cannot keep your appointment:
Should you wish to cancel your appointment, please notify the office at least **24 hours prior to your scheduled appointment time.** Less time than 24 hours' notice will result in a $35 "no show" fee being billed and due prior to rescheduling another appointment.

Any patient who has been deemed excessively abusing the scheduling policy (3 cancellations or 3 reschedules within a 12-month period) will be placed on a "Restrictive Access," meaning the patient will not be allowed to schedule any appointment for 6 months.

MEDICAL HISTORY FORM
Winchester Gastroenterology Associates

Patient Name: _____
Date of Birth:_____

Reason for Visit:_____

DRUG ALLERGIES & REACTIONS

_____ ☐ **None**

MEDICATIONS – Please list all your medications and doses or attach a list. Include vitamins, herbal supplements and over the counter medications.

Medication	Dosage	How often taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY – Please list your current Pharmacy name and address/location.

_____

IMMUNIZATIONS – Please check those you have received and when.

☐ Hep A Date:_____ ☐ Hep B Date: _____ ☐ Flu Date: _____ ☐ Pneumonia: _____
☐ Covid Date & Type: _____ ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other: _____

GI STUDIES – Please check if you have had any of the following GI procedures/studies and list **WHEN** (year it was done) and **WHERE** (location and/or doctor). ☐ **None**

☐ Colonoscopy: When/Where _____
☐ EGD: When/Where _____ ☐ EUS: When/Where_____
☐ ERCP: When/Where: _____

SURGICAL HISTORY – Please list ANY procedures you have had and **WHEN** (year it was done) and **WHERE** (location and/or doctor). If more, please attach list. ☐ **None**

☐ Cholecystectomy: When/Where_____ ☐ Gastric Bypass: When/Where_____
☐ Appendectomy: When/Where_____ ☐Small bowel resection: When/Where_____
☐ Colon resection: When/Where_____☐Spinal Implant: When/Where_____

SOCIAL HISTORY – Please check your responses and fill in blanks where applicable.

Alcohol: ☐ None ☐ Yes: Amount/Frequency _____-_____ Caffeine: ☐ None ☐ Yes Amt_____
Tobacco: Current Smoker? ☐ No ☐ Yes: Amount/Frequency _____
Tobacco: Former Smoker? ☐ No ☐ Yes: Year Quit _____
Recreational drug use? ☐ No ☐ Yes: Type/Frequency _____
Exercise: ☐ No ☐ Yes: Type/Frequency _____

FAMILY MEDICAL HISTORY – Please check all that apply and indicate relationship.
☐ **No Knowledge**

☐ Celiac Disease – Relationship: _____
☐ Colon Cancer – Relationship/Age:_ _____
☐ Ulcerative Colitis – Relationship:_____
☐ Pancreatic Cancer -Relationship: _____
☐ Esophageal Cancer – Relationship:_____
☐ Other – Relationship: _____
☐ Crohn's Disease – Relationship: _____
☐ Colon Polyps – Relationship/Age:_____
☐ Stomach Cancer – Relationship:_____
☐ Uterine Cancer – Relationship:_____
☐ Liver Disease – Relationship:_____

MEDICAL HISTORY FORM
Winchester Gastroenterology Associates

Patient Name: _____
Date of Birth:_____

PATIENT MEDICAL HISTORY – Please check next to conditions that you have presently or have had in the past.

	A fibrillation		COPD		Hepatitis Type?_____		Pulmonary Embolism
	Anemia		Coronary Artery Disease		HIV		Seizures/Epilepsy
	Anxiety disorder		Depression		High Cholesterol		Sleep Apnea
	Arthritis		Defibrillator		High Blood Pressure		Stroke
	Asthma		Diabetes		Hyperthyroidism		Tuberculosis
	Barrett's esophagus		Dialysis		Hypothyroidism		Ulcerative Colitis
	Bleeding/clotting disorder		Diverticulitis/ Diverticulosis		Kidney Disease		**Please list any others:**
	Cirrhosis		GERD/Reflux		Liver Disease		
	Crohn's Disease		Gallstones		Osteoporosis/ Osteopenia		
	Colon Cancer/Yr. dx		Heart Failure		Pancreatitis		
	Colon Polyps/Yr. dx		Heart Disease		Pacemaker		

REVIEW OF SYSTEMS – Please check next to symptoms you have recently experienced.

Constitutional		**Gastrointestinal**		**Neurologic**	
	Fever		Difficult swallowing		Weakness
	Chills		Pain on swallowing		Numbness
	Night Sweats		Indigestion/heartburn		Memory loss
	Weight Gain		Bloating/Gas		Headaches
	Weight Loss		Belching		Dizziness
	Fatigue		Regurgitation	**Psychiatric**	
Eyes/Ears/Nose/Throat			Nausea		Confusion
	Earache		Vomiting		Depression
	Ringing in ears		Decreased appetite		Anxiety
	Loss of hearing		Early satiety		Nervousness
	Nose/Sinus issues		Abdominal pain/discomfort		Insomnia
	Nosebleeds		Diarrhea	**Endocrine**	
	Snoring		Fecal incontinence		Cold intolerance
	Sore Throat		Constipation		Heat intolerance
	Hoarseness		Blood in stool		Excessive thirst
	Mouth sores		Black or tarry stools		Increase urinary frequency
	Feeling of foreign body in throat		Intolerance to dairy	**Musculoskeletal**	
	Change in taste		Rectal itch		Muscle Aches
	Change in vision		Rectal pain		Weakness
Cardiovascular			Rectal bleeding		Joint Pain
	Fainting/lightheadedness		Jaundice	**Hematologic/Lymphatic**	
	Chest pain	**Pulmonary**			Bruising
	Palpitations		Cough		Enlarged lymph nodes
	Limb pain on exertion		Coughing up blood		Excessive bleeding
Genitourinary			Shortness of breath	**Other: Please list any other symptoms**	
	Prostate enlargement		Wheezing		
	Blood in urine	**Integumentary (Skin)**			
	Change in urine		Change in skin color		
	Urine incontinence		Rashes or itching		

Patient/Guardian Signature:_____ **Date:**_____

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PATIENT INFORMATION & ASSIGNMENT OF INSURANCE BENEFITS

PATIENT INFORMATION

LAST_____ FIRST_____ MI_____

SEX _____M _____F BIRTHDATE_____/_____/_____ SS#_____-_____-_____

ADDRESS_____ CITY_____ST_____ZIP_____

CELL PHONE_____ HOME PHONE _____

EMAIL _____ PREFERRED LANGUAGE: ☐ENGLISH ☐SPANISH ☐OTHER_____

RACE: ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE

☐ NATIVE HAWAIIN OR OTHER PACIFIC ISLANDER ☐ OTHER ☐ DECLINE TO SPECIFY

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO SPECIFY

EMPLOYER_____ ADDRESS_____

EMERGENCY CONTACT: _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE _____ MARITAL STATUS _____

PRIMARY CARE PROVIDER _____

REFERRING PROVIDER (IF DIFFERENT): _____

INSURANCE: PRIMARY

NAME_____ ID#_____ GROUP #:_____

NAME OF POLICY HOLDER _____ BIRTHDATE_____/_____/_____

RELATIONSHIP TO PATIENT _____

INSURANCE: SECONDARY

NAME_____ ID#_____ GROUP #:_____

NAME OF POLICY HOLDER _____ BIRTHDATE_____/_____/_____

RELATIONSHIP TO PATIENT _____

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AUTHORIZATION

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, AND I CONSENT TO ANY MEDICAL OR SURGICAL TREATMENT RENDERED UNDER THE GENERAL AND SPECIAL INSTRUCTIONS OF THE PHYSICIAN.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION RELATED TO MEDICAL SERVICES PROVIDED

I, HEREBY, ASSIGN ALL BENEFITS TO WINCHESTER GASTROENTEROLOGY ASSOCIATES, FOR SERVICES RENDERED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I, HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY PHYSICIAN FOR TREATMENT TO INCLUDE COMPLETE MEDICAL RECORDS, TEST RESULTS, AND BILLING INFORMATION TO MY INSURANCE COMPANY, AND TO OTHER MEDICAL PROFESSIONALS AND MEDICAL CARE INSTITUTIONS THAT I MAY BE REFERRED TO FOR TREATMENT. I UNDERSTAND THAT THIS INFORMATION WILL BE USED TO REVIEW, INVESTIGATE, OR MAKE PAYMENT OF A CLAIM, AND TO REVIEW RECORDS FOR QUALITY IMPROVEMENT INITIATIVES, AUDIT COMPLIANCE, UTILIZATION MANAGEMENT, AND COMPLAINT RESOLUTION. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND AS VALID AS THE ORIGINAL.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE TO WINCHESTER GASTROENTEROLOGY ASSOC, AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. I HAVE GIVEN ALL MY INSURANCE INFORMATION FOR BILLING PURPOSES AND UNDERSTAND THE BILLING PROCEDURES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY INCLUDING BUT NOT LIMITED TO, CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES. I ALSO AGREE TO COMPLETE ALL NECESSARY PAPERWORK IN ORDER FOR MY CLAIM TO BE PAID BY MY INSURANCE COMPANY AND ACCEPT FULL LIABILITY FOR ALL CHARGES IF PAYMENT IS NOT MADE IN MY BEHALF BY MY INSURANCE COMPANY.

SIGNED: _____ DATE: _____

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PATIENT FINANCIAL RESPONSIBILITIES

Winchester Gastroenterology Associates wants to provide our community with healthcare services and, at the same time, keep costs under control. Therefore, we ask that you carefully read our financial policy.

- Your bill is based on the service(s) you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- Covered services are based on an agreement between you and/or your employer and your insurance company. Winchester Gastroenterology Associates (WGA) is not a party to that agreement.
- You should contact your insurance company prior to any services provided should you have any questions regarding coverage.
- We know that temporary financial problems can sometimes prevent payments being made on time. If this situation arises, please contact our Patient Accounts Department at once so arrangement for payments can be made.
- Balances due and not paid within ninety (90) days of billing date or, if agreed upon payment arrangements on your account are not made, WGA may retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance.

Patients Without Health Insurance:

All self-pay patients are expected to pay for services in full at the time of registration. New Patient exam fee is $220.00 and our Established Patient exam fee is $150.00. For your convenience we accept cash, check, and all major credit/debit cards.

Patients with Health Insurance:

WGA participates with many insurance companies. Participation means that we have a signed contract with the insurance company to provide care for the people they cover. Each company's contract is different, and certain services may not be covered depending on your employee health benefits. Prior to your appointment, please contact your employer's benefits coordinator or your health insurance company for details of your coverage.

- Co-pays will be due at the time of registration.
- Please provide our office with an updated insurance card(s) at the time of your appointment.
- Please contact your insurance carrier to see if they participate with our practice. If your insurance requires a referral from your Primary Care Physician (PCP), you will

be responsible for obtaining the referral from your PCP prior to your appointment being scheduled.
- All balances due to Winchester Gastroenterology Associates after insurance payments are made are the sole responsibility of the patient or guarantor (if different).

If WGA participates with your insurance plan, our responsibility is:

- WGA will send a bill to your insurance company for all services performed by our providers.
- WGA will make any contractual adjustments required prior to sending you a statement for balance due.

If WGA DOES NOT participate with your insurance plan:

- If you have health insurance that WGA does not participate with, your signature below acknowledges that WGA will not bill your insurance company and payment in full is expected at time of service.
- There will be a $35 service charge for all returned checks.

Patients with Medicare:

WGA will submit your bill to Medicare and any secondary insurance you may have. If your Medicare deductible is not met, you will receive a bill for the deductible. Secondary insurances may or may not pay your Medicare deductible. Regardless of deductible coverage, we will submit all claims to the secondary insurance. If you do not have secondary coverage, you will be billed for any allowable amount not paid by Medicare.

I have read this financial responsibility document and agree to the terms as they apply to my situation.

_____ _____

Patient Signature Date

_____

Patient Printed Name

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS AND RELEASE OF CONFIDENTIAL INFORMATION

1. I, _____ acknowledge the receipt and review of
   (Name of patient or authorized agent)

   Winchester Gastroenterology Associates' (WGA) Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information. I understand that WGA has reserved the right change its privacy practices and that a copy of any revised Notice will be available to me upon written request.

2. I hereby authorize the release of protected health information (PHI) for the purpose of carrying out treatment, payment or healthcare operations as follows:

   a. My complete health record **OR**

   b. My complete health record *with the exception of the following:*

      - Mental health records
      - Communicable diseases (including HIV and AIDS)
      - Alcohol/drug abuse treatment
      - Other (please specify): _____

3. In addition to the authorization for release of my PHI in paragraph 2a or 2b of this authorization, I authorize disclosure of information regarding my health care, treatment, or billing to the following individual(s):

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

4. I understand that I have the right to revoke this authorization in writing at any time. I understand that my revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ _____
Signed Date

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____/_____/_____

Maiden or other name(s): _____ Phone Number: _____

- **Check this box if you are requesting your entire medical record**
  Or Select Specific Records you wish to release:
  - Provider Notes
  - Operative/Procedure Notes
  - Lab Reports
  - Pathology Reports
  - HIV Results/Testing
  - Hospital Records
  - Radiology Reports
  - Infusion Records
  - Other: _____

Date(s) of Treatment:

- All Dates
- Specific Dates: _____ through _____

Reason for use or disclosure (as applicable) is for the purpose of (check one):

- Continuing Medical Care
- Other (Please specify): _____

Obtain Records FROM:	**Send or Fax Records TO:**
_____	_____
(Physician/Institution)	(Physician/Institution)
_____	_____
(Address: Street, City, State, Zip)	(Address: Street, City, State, Zip)
_____	_____
_____	_____
(Phone) (Fax)	(Phone) (Fax)

- I understand that I may revoke this authorization by sending a written request for revocation to Winchester Gastroenterology, Privacy Officer. If I revoke this authorization, Winchester Gastroenterology will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand when Winchester Gastroenterology discloses information pursuant to this authorization, the information may no longer by protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.
- I understand that this authorization will expire in 12 months from the date of signature unless otherwise indicated here: _____

_____ _____ _____

Signature of Patient or Authorization Representative **Date** **Relationship**