PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

PATIENT INFORMATION:

NAME: _____ GENDER: ❑ Male ❑ Female

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____ E-MAIL: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS:

_____
Street / P.O. Box / Apt. No. City / State / Zip Code

MAY WE LEAVE MESSAGES BY:	EMAIL	TEXT CELL	HOME PHONE	WORK PHONE	CELL PHONE
FOR TEST RESULTS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
FOR APPOINTMENT REMINDERS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

DOMESTIC INFORMATION:

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

SPOUSE/OTHER NAME: _____ DATE OF BIRTH: _____

EMPLOYER: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

PREFERRED LANGUAGE: ***Must complete.*** ❑ English ❑ Spanish ❑ Other: _____

PATIENT ETHNICITY: ***Select one.*** ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: ***Select one or more.*** ❑ African American ❑ American Indian or Alaska Native ❑ Asian
❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

INSURANCE INFORMATION:

We require copies of ALL Insurance Cards in order to file your insurance claims.

PRIMARY INSURANCE: _____ INS ID#: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____

SUBSCRIBER'S ADDRESS: _____

SS #: _____ DOB: _____ PHONE: _____

SECONDARY INSURANCE: _____ INS ID#: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____

SUBSCRIBER'S ADDRESS: _____

SS #: _____ DOB: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET

IF SERVICES ARE BEING PROVIDED TO YOUR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

MOTHER/GUARDIAN: _____ DOB: _____ SS#: _____

ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

FATHER/GUARDIAN: _____ DOB: _____ SS#: _____

ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

I hereby authorize Galen Medical Group, its physicians and staff, to render appropriate medical care to my dependent listed under the patient information section on the front of this form.

_____ _____
Signature of Responsible Party ***Date***

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, my physician's plans for health care, etc.

Signature: _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED

ADVANCED DIRECTIVES:

It is the right of every adult citizen in Tennessee and Georgia (18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Health Care that empowers an Individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION:

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I request that payment of Medicare, MediGap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial, Workers' Compensation, Liability, and/or any other insurance benefits be made on my behalf to Galen Medical Group for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____ _____
Signature of Patient ***Date*** ***Signature of Responsible Party/Insured***

THANK YOU

Gastroenterology Evaluation Form

Name: _____ **DOB:** _____ **Sex: M F Date:** _____

Referring Doctor: _____ **Primary Care Provider:** _____

Cardiologist: _____ **Other Providers:** _____

Vaccination/ Immunization

Vaccination/ Immunization	Date of vaccination/ immunization (MM/YYYY)	Did not receive immunization (Mark X here)
Last Influenza- flu shot		
Pneumococcal- pneumonia shot		

Allergy List

Medication, Environmental, and/or Food	Reaction
Reaction to Anesthesia: ☐ Yes ☐ No If yes, what type of reaction: _____	

Medical History (Please check all that apply)

☐ High Blood Pressure ☐ Emphysema ☐ Heart Attack ☐ Shortness of Breath
☐ Kidney Disease ☐ Abnormal Heart Rhythm ☐ Diabetes ☐ Arthritis
☐ Chest Pain ☐ Stroke ☐ Migraines ☐ Asthma
☐ Kidney Stones ☐ Seizures ☐ Tuberculosis ☐ COPD
☐ Depression ☐ Sleep Apnea ☐ Blood Clots ☐ Blood Disorder
☐ Glaucoma ☐ HIV/AIDS ☐ Cancer(s): _____
☐ Other: _____

Surgeries

☐ Tonsils and Adenoids ☐ Hysterectomy (Year: ___) ☐ Hernia Repair ☐ Appendix
☐ Joint Replacement ☐ Hemorrhoid ☐ Gallbladder ☐ Heart
☐ Pancreas ☐ Thyroid ☐ Colon Resection (Year:___) ☐ Breast (Year:____)
☐ Nissen Fundoplication ☐ Pacemaker (Year:____) ☐ Defibrillator (Year:____) ☐ Organ Transplant
☐ Cardiac Stent (Year:____) ☐ Abdominal Surgeries: _____
☐ Other: _____

Procedure History (Please check all that you have had in the past)

☐ Colonoscopy, year was it done? _____ By whom? _____
☐ EGD (Upper Endoscopy) ☐ ERCP ☐ EUS (Endoscopic Ultrasound)

Preventive

Last Mammogram **(month & year):** _____ Last Pap-smear **(month & year):** _____

Medication List

☐ **I am on a blood thinner** (if so, please list below) Who Prescribes? ______________________________

Name of Medication	Dose (mg, mcg, units)	Times Taken Per Day, Week, Month, or Year

My Pharmacy: ____

Patient Name: ____ **DOB:** __________________________

Social History

Tobacco

☐ Current everyday smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Cigarettes ☐ Chew ☐ Cigars Packs per day _____ How many years _____ Year quit _____

Alcohol Use

☐ No ☐ Never ☐ Previous ☐ Current ☐ History of alcoholism

How often? ☐ Rare ☐ Socially ☐ Regularly ☐ Heavy Type: ☐ Beer ☐ Liquor ☐ Wine

Illicit Drug Use

☐ Never ☐ Current ☐ Previous Years Sober: _____

☐Marijuana ☐ Cocaine ☐ Heroin ☐ Methamphetamine ☐ Other: _____

Work History

☐ Full-time ☐ Part-time ☐ Homemaker ☐ Disabled ☐ Retired ☐ Student

Living Situation

☐ Alone ☐ Lives with family ☐ Spouse ☐ Other: _____

Exercise

☐ Never ☐ Rarely ☐ Occasionally ☐ Regularly- timer per week: _____

Exposures

☐ Tattoos, if so how many? _____ ☐ Blood Transfusion, if so how many? _____

Diet

☐ High Fiber ☐ Low Fiber ☐ Vegetarian ☐ Vegan ☐ Caffeine Use, if yes how much _____

Use of NSAIDS

☐ Aspirin ☐ Advil ☐ Aleve ☐ Goody's ☐ Ibuprofen ☐ Naproxen ☐ Excedrin

Family Medical History

(Please enter one of the following in the blank space: F= Father, M=Mother, B=Brother, S=Sister, C=Child)

____ Colon Polyps	____ Esophageal Cancer	____ Irritable Bowel Syndrome	____ Colon Cancer
____ Stomach Cancer	____ Esophageal Reflux	____ Colitis	____ Gallbladder Disease
____ Pancreatitis	____ Crohn's Disease	____ Breast Cancer	____ Pancreatic Cancer
____ Liver Disease	____ Stomach Ulcers	____ Prostate Cancer	____ Blood Disorders

Other: _____

Review of Systems (current symptoms)

General: ☐ Fever ☐ Chills ☐ Fatigue ☐ Decreased Appetite ☐ Weight Loss ☐ Weight Gain

Psychiatric: ☐ Depression ☐ Anxiety ☐ Stress

Skin: ☐ Rash ☐ Skin Change ☐ Itchiness ☐ Jaundice

Eyes: ☐ Jaundice ☐ Glaucoma

Ears: ☐ Ear Pain ☐ Hearing Loss ☐ Ringing of Ears ☐ Ear Fullness ☐ Ear Drainage

Nose: ☐ Nasal Congestion ☐ Nose Bleeds

Mouth/Throat: ☐ Dentures ☐ Dry Mouth ☐ Mouth Ulcers ☐ Hoarseness ☐ Trouble Swallowing ☐ Painful Swallowing

Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Cough ☐ Home Oxygen ☐ Trouble Breathing ☐ Sleep Apnea

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Congestive Heart Failure ☐ Murmur ☐ Heart Attack ☐ Angina

Gastrointestinal: ☐ Seen other GI Doctor(s) ☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Abdominal pain ☐ Heartburn ☐ Reflux ☐ Belching ☐ Gas ☐ Bloating ☐ Nausea ☐ Vomiting ☐ Difficulty Swallowing ☐ Painful Swallowing ☐ Diarrhea ☐ Constipation ☐ Blood in Stool ☐ Black Stools ☐ Change in bowel habits ☐ Mucus in Stool ☐ Pain with Bowel Movement ☐ Straining During Bowel Movement ☐ Urgency with Stools ☐ Stooling Accidents ☐ Rectal Pain ☐ Hemorrhoids ☐ Colon Polyps ☐ Diverticulitis ☐ Change in Stool Caliber

Genitourinary: ☐ Frequent Urination ☐ Incontinence ☐ Blood in Urine ☐ Heavy Periods ☐ History of Bladder/Kidney Infections ☐ History of Kidney Stones

Neurological: ☐ Dizziness ☐ Headaches ☐ Fainting ☐ History of Stroke ☐ Seizures

Musculoskeletal: ☐ Arthritis ☐ Osteoporosis ☐ Fractures ☐ Joint Pain ☐ Muscle Pain

Endocrine: ☐ Thyroid Problems ☐ Diabetes ☐ Hormone Imbalance ☐ Heat Intolerance ☐ Cold Intolerance

Hematologic/Lymph: ☐ Excessive Bruising ☐ Excessive Bleeding ☐ History of Blood Transfusion ☐ History of Anemia

Immunologic: ☐ Food Allergies ☐ Frequent Infections ☐ Frequent Steroid Use ☐ Problems with Immunity

Patient Name: _____ **DOB:** _____

GALEN
MEDICAL GROUP

Financial Policy

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. Galen Medical Group makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance

Insurance companies require Galen Medical Group to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

A $12.00 processing fee will be added for co-pays that are not paid at the time of service.

Outstanding Balances

Patients will be asked to settle any outstanding balances with Galen Medical Group before their appointment. As a patient, you may pay any outstanding balances at any of our Galen Medical Group facilities.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay

Galen Medical Group recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Galen will try to work with the patients to help them anticipate charges and manage their healthcare expenses.

Patients without insurance who pay in full at the time of service may be eligible for a discount.

For patients without insurance or the resources to pay for care, Galen supports the Volunteers In Medicine Clinic, a free primary care clinic located at 5705 Marlin Road in Chattanooga. Residents of Hamilton County who qualify can receive free care from Galen Medical Group physicians and other physicians who volunteer at the clinic.

Billing Insurance

Galen Medical Group contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received. If payment is not received within 30 days, 10% interest will be applied to the outstanding balance until the account is paid in full.

No-show and Late cancellation Fee

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $25.00 fee, not for any service, but for the lost opportunity to see another patient. Patients who cancel appointments with less than 72 hour's notice may be subject to a $200 fee for procedures.

Payments

Galen Medical Group accepts cash, check, Visa, MasterCard or Discover. There is a $30.00 fee for all returned checks.

Payment can be sent to:	**To bring payment in person:**	**To Pay Online:**
Galen Medical Group	Eastgate Mall	www.galenmedical.com
P.O. Box 1030	5600 Brainerd Rd. Suite H-100	
Chattanooga, TN 37401	Chattanooga, TN 37411	

If you have any questions regarding our financial policies, please contact our Patient Business Services Representative at **(423) 894-3725**.

NOTE:

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay interest on the balance at 10%, plus all costs associated with such collection activity, including reasonable collection agency fees, attorney fees, and court costs.

_____ _____

Patient Signature Date

_____

Printed Patient Name