The GI Guy
KURT VERNON, MD, FACG
COLON, RECTAL, LIVER & DIGESTIVE DISORDERS
Compassionate, convenient health care.

PATIENT INFORMATION

Social Security Number	First Name	Middle Name	Last Name

Address	☐ Single ☐ Married ☐ Widowed ☐ Divorced

City	State	Zip	Home Phone

Email address	Family Doctor Phone	Cell Phone

Employer	Work/Daytime Phone	Birth Date	Sex ☐ Male ☐ Female

PLEASE ALLOW RECEPTIONIST TO MAKE A COPY OF YOUR INSURANCE CARD.

INSURANCE INFORMATION

PRIMARY		SECONDARY	
	Insurance Carrier		Insurance Carrier
	Name of Policy Holder		Name of Policy Holder
	Insurance ID Number		Insurance ID Number
	Address of Insurance Company		Address of Insurance Company
	Phone # of Insurance Co. / Employer of Policyholder		Phone # of Insurance Co. / Employer of Policyholder
	Sex of Policy Holder ☐ Male ☐ Female DOB:		Sex of Policy Holder ☐ Male ☐ Female DOB:
	Patient's Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other:		Patient's Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other:

WHO MAY WE THANK FOR REFERRING YOU?

REFERRAL SOURCE

Name	Address	Phone No.
☐ Doctor		

Name

☐ Friend ☐ Yellow Page Ad ☐ Hospital ☐ Internet ☐ Other:

IN CASE OF EMERGENCY PLEASE NOTIFY

Name					
Address					
City	State	Zip	Work Phone	Home Phone	Ext.

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PATIENT'S RESPONSIBILITY / MEDICAL RELEASE / ASSIGNMENT OF BENEFITS

I hereby acknowledge responsibility for any professional fees incurred and for obtaining any referral needed.
I authorize release of medical information necessary to process my insurance claims.
I request that payment of authorized benefits be made to Kurt Vernon MD PA for services furnished to me by them.

Please provide your insurance card(s) at each visit or you may be asked to reschedule your appointment. **Please bring your medications or a current list of your medications to each office visit! Thank you.**

Signature	Relationship to Patient	Date

Accredited by the
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

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MEDICATION LIST

Name:	**Address:**
Phone Number:	
Date of Birth:	

Allergic To/Describe Reaction:	**Pharmacy:**
	Phone:
	Address:

List all prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort) Include prescription meds taken as needed, (ex. Viagra, Nitroglycerin.)

DATE	NAME OF MEDICATION	DOSAGE OF MEDICATION (EX. MG, MCG)	DATE OF LAST DOSE:	Reason for taking / MD Name

IMMUNIZATION RECORD (Record the last dose taken)
TETANUS
PNEUMONIA VACCINE
FLU VACCINE
HEPATITIS VACCINE

OFFICE USE ONLY

UPDATED_____BY_____ UPDATED_____BY_____ UPDATED_____BY_____

Patient Signature_____Date:_____

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FINANCIAL POLICY

This is an agreement between Kurt Vernon MD PA a North Carolina Professional Corporation, as creditor, and the Patient/Debtor named on this form. In this agreement the words "you, your, and yours" mean the patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Kurt Vernon MD PA

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:

1. You choose to pay by cash, check, or credit card on the day for services being rendered.
2. For procedures the cost needs to be paid prior to your procedure.
3. On extensive treatment or procedures, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

1. You must pay your deductible of and any out-of-pocket portions at the time services are rendered by cash, check, or credit card.
2. If you choose to pay all of your treatment by cash, check, or credit card, you will need to file appropriate insurance forms for reimbursement.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Credit History: We have the option to report your account status to any credit reporting agency such as a credit bureau.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

The Financial Policy continues on the back side of this page.

DUNN OFFICE: 604-C Dunn Erwin Rd. Dunn, NC 28334 Phone: (910)891-5808 Fax: (910) 891-5323
FUQUAY-VARINA OFFICE: 1004 Procure St. Fuquay-Varina, NC 27526Phone: (919) 577-0085 Fax: (919) 577-0013
www.giguy.net

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Re-filing fee: There is a fee (currently $15) for any additional insurance information that causes a refilling status, such as not providing all insurance related information or additional insurance not originally filed.

Missed appointment fee: The second time a patients does not show up on time for an appointment, or cancels with less than 24 hours notice, a $20 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Harnett County, North Carolina.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent=s responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workman's Compensation: We require written approval/authorization by your employer and/or worker=s compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient=s responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

By executing this agreement, you are agreeing to pay for all services that are received.

Patients name: _____

Responsible party
(if not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF PSYCHIATRIC & MEDICAL INFORMATION

I, _____, do hereby consent and authorize _____

(Patient Name) (Name of Releasing Facility)

to use and/or disclose my health information to: _____ _____

(Name of Receiving Facility)

The information relating to my identity, diagnosis, prognosis, and care plan. I understand that the specific type of information to be disclosed includes:

_____ Please send the entire medical record (all information) _____ Aids or HIV Test results if applicable

_____Colonoscopy/Pathology _____ Clinician office chart notes _____ Transcribed hospital reports

_____ Laboratory reports _____ Medical records needed for continuity of care _____ X ray reports

_____ Hospital notes _____ Consultation notes _____ Diagnostic imaging reports _____ Other

The purpose or need of this disclosure is for further medical evaluation and medical care. All records are confidential and treated as such. Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the practice**.** Unless revoked earlier, this Authorization will expire 30 days from the date of signing.

PATIENT DEMOGRAPHICS:

Patient Name:_____ DOB:_____ Social Security Number:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

_____ _____

Patient 's Signature or Individual 's Legal Representative /Relationship Date

Witness Signature:_____Date: _____(witness signature only)

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Protected Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors receive training so that they may understand and comply with government rules and regulations regarding the Health Information Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

A complete copy of our Disclosure of Portability Statement is available upon request.

Thank you for being one of our valued patients.

Patient Signature:_____Date:_____

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Name: _____ DOB:_____

You will soon have an endoscopic procedure at the office of Kurt Vernon MD PA. You will receive IV Sedation for your procedure. The IV Sedation will be administered by a Certified Register Nurse Anesthetist. In order for the Nurse Anesthetist to safely administer sedation, you will need to provide us some information regarding your health status. This form must be completed and returned to our office prior to your appointment. You can fax to **(910) 891-5323.** You will receive a call once information has been reviewed to schedule your appointment. Thank You.

A. Are you taking any medications including over the counter, if so please write the names here
_____
_____
_____

B. Do you take any of the following: Aspirin, Plavix, Coumadin, NSAIDs if so Last Dose_____
C. Do you take any illegal drugs: **Yes / No**
D. Do you have any problems with heart, blood pressure, kidneys, lungs, diabetes, seizure disorders, arthritis, depression, nervous disorders, migraines, organ transplants (Circle all that apply) _____
E. Please list any previous surgeries and date of the surgery_____
_____
F. Please list any previous procedures and date of the procedure_____
_____
G. Have you ever had an anesthetic for surgery? **Yes / No**
H. Did you have any complication with anesthesia? **Yes / No** What type of problem?_____
_____
_____
I. Has anyone in your family ever had a problem with anesthesia? **Yes / No**_____
J. Do you have a family history of colon cancer (who) _____
K. Are you allergic to any **medications** or **latex, eggs, peanut**, or **soy allergies** (Circle all that apply) Describe your reaction_____
Are you allergic to eggs? (One of our medications is egg based, and if you are allergic we will need to choose another type of medication) **Yes / No**
L. Do you smoke or use tobacco products? **Yes/ No**_____ Do you drink alcohol **Yes / No**_____
M. How much do you weigh? _____ How tall are you?_____
N. Do you have sleep apnea? **Yes/No** _____
O. How many pillows do you sleep on at night? **One, two, or three**
P. Who may we list in your chart as your emergency Contact Name:_____
Relationship: _____Contact Number: (1)_____(2)_____
Q. Is there anything you would like for us to know about your health that will help us to take better care of you that has not been discussed in previous questions?_____
_____
_____
_____
_____

SIGNATURE:_____ DATE:_____

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A. Are you taking any medications including over the counter, if so please write the names here
_____
_____
_____

B. Do you take any of the following: Aspirin, Plavix, Coumadin, NSAIDs if so Last Dose_____
C. Do you take any illegal drugs: **Yes / No**
D. Do you have any problems with heart, blood pressure, kidneys, lungs, diabetes, seizure disorders, arthritis, depression, nervous disorders, migraines, organ transplants (Circle all that apply) _____
E. Please list any previous surgeries and date of the surgery_____
_____
F. Please list any previous procedures and date of the procedure_____
_____
G. Have you ever had an anesthetic for surgery? **Yes / No**
H. Did you have any complication with anesthesia? **Yes / No** What type of problem?_____
_____
_____
I. Has anyone in your family ever had a problem with anesthesia? **Yes / No**_____
J. Do you have a family history of colon cancer (who) _____
K. Are you allergic to any **medications** or **latex, eggs, peanut**, or **soy allergies** (Circle all that apply) Describe your reaction_____
Are you allergic to eggs? (One of our medications is egg based, and if you are allergic we will need to choose another type of medication) **Yes / No**
L. Do you smoke or use tobacco products? **Yes/ No**_____ Do you drink alcohol **Yes / No**_____
M. How much do you weigh? _____ How tall are you?_____
N. Do you have sleep apnea? **Yes/No** _____
O. How many pillows do you sleep on at night? **One, two, or three**
P. Who may we list in your chart as your emergency Contact Name:_____
Relationship: _____Contact Number: (1)_____(2)_____
Q. Is there anything you would like for us to know about your health that will help us to take better care of you that has not been discussed in previous questions?_____
_____
_____
_____
_____

SIGNATURE:_____ DATE:_____