BUX-MONT GASTROENTEROLOGY ASSOCIATES
1107 BETHLEHEM PIKE SELLERSVILLE
PATIENT QUESTIONAIRE

**Patient Name: _____**

**General/Constitutional**

| | | | | |
|---|---|---|---|---|
| Fatigue | O | Yes | O | No |
| Fever | O | Yes | O | No |
| Weight loss | O | Yes | O | No |
| Night sweats | O | Yes | O | No |
| Weight Gain | O | Yes | O | No |

**ENT**

| | | | | |
|---|---|---|---|---|
| Sore throat | O | Yes | O | No |
| Sinus pain | O | Yes | O | No |
| Hoarseness | O | Yes | O | No |

**Respiratory**

| | | | | |
|---|---|---|---|---|
| Cough | O | Yes | O | No |
| Shortness of breath at rest | O | Yes | O | No |
| Shortness of breath with exertion | O | Yes | O | No |
| Wheezing | O | Yes | O | No |

**Cardiovascular**

| | | | | |
|---|---|---|---|---|
| Chest pain at rest | O | Yes | O | No |
| Chest pain with exertion | O | Yes | O | No |
| Irregular heartbeat | O | Yes | O | No |
| Palpitations | O | Yes | O | No |

**Gastrointestinal**

| | | | | |
|---|---|---|---|---|
| Decreased appetite | O | Yes | O | No |
| Blood in stool | O | Yes | O | No |
| Heartburn | O | Yes | O | No |
| Change in bowel habits | O | Yes | O | No |
| Difficulty swallowing | O | Yes | O | No |

**Hematology**

| | | | | |
|---|---|---|---|---|
| Easy bruising | O | Yes | O | No |
| Prolonged bleeding | O | Yes | O | No |
| Swollen glands | O | Yes | O | No |

**Patient Name: _____**

**Musculoskeletal**

| | | | | |
|---|---|---|---|---|
| Painful joints | O | Yes | O | No |
| Swollen joints | O | Yes | O | No |
| Leg cramps | O | Yes | O | No |
| Joint stiffness | O | Yes | O | No |
| Muscle aches | O | Yes | O | No |
| Chronic Pain | O | Yes | O | No |

**Skin**

| | | | | |
|---|---|---|---|---|
| Itching | O | Yes | O | No |
| Rash | O | Yes | O | No |
| Edema | O | Yes | O | No |
| Discoloration | O | Yes | O | No |

**Neurologic**

| | | | | |
|---|---|---|---|---|
| Seizures | O | Yes | O | No |
| Involuntary movements | O | Yes | O | No |
| Tremor | O | Yes | O | No |
| Tingling/Numbness | O | Yes | O | No |
| Loss of strength | O | Yes | O | No |

**Psychiatric**

| | | | | |
|---|---|---|---|---|
| Anxiety | O | Yes | O | No |
| Difficulty sleeping | O | Yes | O | No |
| Loss of appetite | O | Yes | O | No |
| Suicidal thoughts | O | Yes | O | No |
| Eating disorder | O | Yes | O | No |
| Depression | O | Yes | O | No |

If you are here for a Colonoscopy or Endoscopy, please check all that apply:

____ My Primary has recommended a screening colonoscopy my age is _____

____ This is my first Colonoscopy/EGD

____ I have had a Colonoscopy/EGD performed at _____ by _____

## PAYMENT POLICY FOR BUX-MONT GASTROENTEROLOGY ASSOCIATES

**1. Insured Patients.** We do participate with many insurance plans and will gladly submit to them your information. The co-pay is part of your contract with your insurer. **You are responsible for your co-pay at the time of service.** If you do not have your co-pay we will exercise our option to reschedule your visit. To not collect the co-pay is fraud on our behalf. Deductibles will be billed to you after notification from your insurer to this office. At that time payment is expected within 10 days of our statement. You must present a valid insurance card at the time of service. *Knowing your insurance is your responsibility.* You need to take responsibility to contact your insurance company for the particulars of your coverage.

**2. Non-Insured Patients.** If you are not insured by a plan that we participate with or have insurance coverage at all, *payment is expected at the time of your visit.* If you cannot make payment in full a minimum payment of $50 for a consult/new patient visit is required prior to your seeing the doctor. This will not be billed out for later payment. A procedure requires a $100 deposit. Both the $50/$100 is a deposit and is not the full amount that you are responsible to pay. We will gladly work with you on a payment plan.

**3. Colonoscopy.** A colonoscopy is considered diagnostic when the patient is experiencing a symptom that requires further examination. A screening colonoscopy is done when there is an absence of symptoms or problems or your family physician has determined that this be done because of age or family medical history. A screening colonoscopy may fall under the wellness/preventative benefits of your policy. While we may obtain the pre-cert for this procedure it will only be covered if your policy includes it. This is very important that you personally look over your policy and that you call your insurer to make sure they will pay for the procedure.

**4. Payment Methods.** We accept *Visa, MasterCard*, checks or cash. If you write us a check and it comes back "marked insufficient funds" we will assess a $30 charge to your account for reprocessing.

**5. Non-Payment.** If your account is 90 days past due, you will receive a final letter stating that we will exercise our options to collect moneys owed to us either by turning the account over to Arcadia Collection Agency or by filing a claim in small claims court if you do not respond in 10 days from the date of the letter. While we hesitate to do this we will pursue moneys owed to the practice. ***If we need to send your account to collections you will be responsible for any charges of the collection agenc***y. Also please be aware that if a balance remains unpaid you will be discharged from the practice for failure to make an honest attempt at payment. If this does occur you will receive notification by both regular and certified mail that you have 30 days to find other medical care.

**6. Changes in Coverage.** It is your responsibility to notify this office of any changes in your medical coverage. Failure to do this may result in the entire amount of moneys owed being billed directly to you the patient. If your insurance has been terminated you are responsible for the entire amount owed.

**While our physicians are dedicated to your health care, you the patient must recognize that in order to continue serving you we must charge for services as they are delivered to you. It is your responsibility to pay for these services as they occur so that our physicians and staff may continue to serve you 24-7. Thank you.**

**I understand the payment policy in full and agree to the financial responsibility for myself/dependents for all medical services rendered thereof:**

_____ _____

Signature of Patient Responsible Party Today's Date

## Patient Information

**Last Name:** _____ **First Name:** _____ **MI:** _____

**Home Address:** _____

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

**Can we leave a message at: Home** _____ **Work:** _____ **Cell:** _____

**Date of Birth:** _____ **Sex:** _____ **Marital Status:** _____

**Social Security Number:** _____ **Email Address:** _____

**Primary Care Physician:** _____ **Referred By:** _____

**Primary Language:** _____ **Interpreter Needed:** _____

**Race:** *Please select one*

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Other Race: _____
- ☐ White
- ☐ Hispanic
- ☐ Refuse to Report
- ☐ Asian
- ☐ Native Hawaiian

## Insurance Information

**Insurance Name:** _____
**Subscriber Number:** _____
**Subscriber's Name:** _____
**Subscriber's Date of Birth:** _____

## Secondary Information

**Insurance Name:** _____
**Subscriber Number:** _____
**Subscriber's Name:** _____
**Subscriber's Date of Birth:** _____

## Medical Information

**Pharmacy:** _____ **City:** _____ **Phone:** _____

**Emergency Contact:** _____ **Relation:** _____ **Phone:** _____

**To whom may we speak to about your medical care:** _____

_____

## Authorization

I authorize the release of medical information necessary to process medical benefits and I authorize payment of medical benefits to Bux-Mont Gastroenterology Associates for services by her office.

Signed _____ Date: _____

Patient name: _____

## HIPAA Notice of Patient Privacy Practices

I acknowledge receipt of Bux-Mont Gastroenterology Associates practice privacy notice. I may request an additional copy of the privacy notice at any time.

Signed _____ Date: _____

## Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers:

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Signed _____ Date: _____

## Consent for RX Hub Inquiry

I hereby provide my consent for the Practice of Bux-Mont Gastroenterology Associates to obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Signed _____ Date: _____