ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

Joseph D. Hollier, MD Kimberly Sills, FNP	1587 N. Bolton Avenue Suite 1100 Alexandria, LA 71303 (318) 473-8188	Mailing Address 1587 N. Bolton Avenue Suite 1100 Alexandria, LA 71303

This letter is designed to answer questions you may have regarding your medical care. Our medical staff, receptionists, secretaries, and nursing personnel operate as a team. We take great pride in our training, knowledge and capabilities, and we are dedicated to giving you quality care.

OFFICE HOURS

Regular office hours are 8:00 a.m. to 5:00 p.m. Monday through Thursday, Friday 8:00 a.m. to 12:00 noon. We will try to see you at the scheduled time. We believe strongly in the value of your time and will do our best to keep you from having to wait for a long time. On occasion, emergencies can cause problems and whenever possible, you will be fully informed if there will be any delays. We would appreciate 48 hour notice if you find it necessary to cancel your appointment.

TELEPHONE CALLS

Our telephones are answered 8:00 a.m. to 5:00 p.m. Our employees have been instructed to handle all incoming calls. This allows the doctors to attend to their scheduled patients with a minimum of interruptions during office hours

PRESCRIPTIONS AND REFILLS

Just as we cannot treat illnesses over the telephone, we cannot prescribe medications over the telephone. Medication refills will only be handled during regular office hours and **only** if you are currently under our care. If you need a prescription refill, have the name and/or number of the medication, the pharmacy telephone number, and the dosage schedule handy when you call. Please call before 2:00 for your refills. Any calls after this time will be handled the following day. Because of our office schedule, calls to the pharmacies for refills are made in the late afternoon.

FEES AND PAYMENT

We make every effort to keep the cost of your medical care to a minimum. You can help by paying at the time of your visit. This is expected unless prior financial arrangements have been made.

INSURANCE

We try to simplify the preparation of insurance claims, thereby holding down the costs which are unrelated to the delivery of good medical care. Our office will file your insurance for all hospital admissions or outpatient procedures. For those who have Medicare insurance, we do accept assignment and will file all charges including office visits. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, coinsurance, or any balance not paid for by your insurance company. We know questions can arise on insurance matters and these should be discussed with our insurance clerk. We will be happy to help you receive maximum benefits; however, the agreement of the insurance company to pay for medical care is a contract between you and your insurance company.

PATIENT CARE

AGA is a specialty clinic, specializing in gastroenterology and hepatology. All of our patients are received through a physician referral. Our patients are either referred for routine colon cancer screening or gastroenterology/hepatology disorders. We will do the appropriate studies such as endoscopy and tests. **The patient will then be referred back to the primary physician with our results and plan of care.** For the patients with liver disease, inflammatory bowel disease, or Barrett's esophagus, we will continue to follow these patients in our established patient clinics.

The best health care is based on friendly mutual understanding among staff, doctor, and patient. We are looking forward to getting to know you!

Revised 02/14/2023

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

How do you plan to pay for this visit? Cash/Check_________ Visa/Mastercard__________ Insurance__________

Do you have a Medical Power of Attorney? ☐Yes ☐No Do you have a Living Will? ☐Yes ☐No

*****PLEASE PRINT*****

PATIENT____DATE OF BIRTH_____________AGE___________

ADDRESS______________________________________CITY/STATE___________________ZIP_____________

SOCIAL SECURITY #____________________MARITAL STATUS: S / M / D / W GENDER: Male / Female

HOME #_______________________WORK #________________________CELL #_______________________

YOUR EMAIL ADDRESS FOR **PATIENT PORTAL ACCESS**____

RACE (circle one): African American Hispanic Caucasian Other: ________________REFUSE TO REPORT

ETHINICITY (circle one): Non-Hispanic Hispanic Other: _______________________ REFUSE TO REPORT

LANGUAGE: English Spanish Sign Language Other: ____

EMPLOYED BY____________________________________OCCUPATION_____________________________

SPOUSE___________________________EMPLOYED BY______________________WK #_________________

RESPONSIBLE PARTY (if different from above) ____

ADDRESS____

EMPLOYED BY____________________________________ PHONE #________________________________

EMERGENCY CONTACT (other than spouse or parent) ____

REFERRED BY ________________________________PHARMACY YOU USE___________________________

<u>INSURANCE INFORMATION</u>

PRIMARY INSURANCE CO._______________________________PHONE #___________________________

ADDRESS____

POLICY OR I.D.#___________________________________ GROUP #_________________________________

SUBSCRIBER____________________________________SUBSCRIBER DOB_____________________________

SECONDARY INSURANCE CO_______________________________PHONE #_________________________

ADDRESS____

POLICY OR I.D. #____________________________________ GROUP#_______________________________

SUBSCRIBER __________________________________ SUBSCRIBER DOB______________________________

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

REQUIRED SIGNATURES

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION (ALL INSURANCES):

I request that payment of authorized insurance benefits be made on my behalf to Alexandria Gastroenterology Associates for any services furnished. I authorize any holder of medical information about me to be released to the insurance carrier and its agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary insurance carrier benefits be made on my behalf to Alexandria Gastroenterology Associates. I authorize any holder of medical information about me be released to Medigap/Secondary insurance carrier and its agents to determine benefits to determine benefits payable for related services. I understand that I do not need to provide my Medigap/Secondary insurance carrier with information concerning Medicare claims because my signing of this authorization will allow Medicare payment information to cross-over automatically.

Signature: ____ Date: _________________________

ALL PATIENTS (REQUIRED):

I understand that as a courtesy Alexandria Gastroenterology Associates will bill my insurance carrier for services rendered. I understand that I am financially responsible and agree to all charges for myself and for the members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon. In the event, legal action should become necessary to collect an unpaid balance due. I agree to pay reasonable attorney fees and other such costs as determined by the court.

Signature: ____Date: _________________________

CONSENT TO OBTAIN EXTERNAL Rx HISTORY:

I_____________________________________ whose signature appears below, authorize Alexandria Gastroenterology Associates and its affiliated providers to view my external prescription history via the RxHub services. I understand that prescription history from multiple other unaffiliated medical providers and staff here, and it may include prescriptions back in time for several years.

Signature: ____Date: __________________________

ACKNOWLEDGEMENT OF HIPAA:

I ______________________________________ whose signature appears below, have the right to review the Notice of Privacy Practices prior to signing this consent. **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists, Cardiac and Vascular Services of Cenla and Alexandria Gastroenterology Associates** reserve the right to revise their Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to office manager, 1587 North Bolton Ave., Suite 1100, Alexandria, La 71303.

Signature: ____ Date __________________________

Revised 02/14/2023

HIPAA Release Form for Individuals Involved in Care of Patient:

I, give Dr. Hollier and Kimberly Sills, FNP-C permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payments for health services that I receive from A. G. A.

**[ ] NONE. My medical records are not to be released to anyone.

This consent is valid until such time as I provide A. G. A. written revocation of it.

Dr. Hollier and Kimberly Sills, FNP-C may speak with:

Name: ____

Relationship: ____

Phone: ____

Name: ____

Relationship: ____

Phone: ____

Name: ____

Relationship: ____

Phone: ____

Name: ____

Relationship: ____

Phone: ____

Name: ____

Relationship: ____

Phone: ____

**** This form is to be filed in the patient's medical record.**

Name: ____ **Date:** ____________________

Pharmacy Information
Name of Pharmacy:
Location:
Rx ID:

ROS (each question below needs to be answered):		
Circle Y=Yes / N=No	**Symptom**	
Y / N	**Chest Pain**	While exercising, do you have chest pain?
Y / N	**Palpitations**	Do you feel your heart racing too fast?
Y / N	**Irregular Heart Beat**	Does your heart beat to slow or fast?
Y / N	**Edema**	Do you have swelling in your ankles?
Y / N	**Shortness of Breath**	Are you short of breath when you walk?
Y / N	**Cough**	Do you have a chronic cough?
Y / N	**Leg Cramps**	Do your legs cramp with exercise?
Y / N	**Weight Loss**	Have you lost weight recently?
Y / N	**Fever**	Are you having any fever?
Y / N	**Night Sweats/Chills**	Are you having night sweats or chills?
Y / N	**Fatigue**	Do you feel tired or weak?
Y / N	**Headaches**	Do you have frequent headaches?
Y / N	**Anemia**	Have you ever been anemic?
Y / N	**Bleeding Problems**	Do you have any bleeding problems after surgery or with cuts?
Y / N	**Numbness**	Does any part of your body get numb?
Y / N	**Seizures**	Have you ever had seizures?
Y / N	**Memory Loss**	Do you have any unusual memory loss?
Y / N	**Depression**	Do you feel depressed or sad?
Y / N	**Difficulty Swallowing**	Do you have problems swallowing solids and/or liquids?
Y / N	**Rectal Bleeding**	Are you experiencing any rectal bleeding? If so, is it bright red, maroon, or black?
Y / N	**Abdominal Pain**	Are you experiencing any abdominal pain? Upper, Lower, or Diffuse?
Y / N	**Nausea/Vomiting**	Are you experiencing any nausea and/or vomiting?
Y / N	**Change in Bowel Habits**	Are you experiencing any diarrhea, constipation, or changes in bowel pattern?
Y / N	**Colonoscopy**	Have you ever had a colonoscopy?
Y / N	**Liver Disease**	Do you have any problems with liver disease? Have you ever had Hepatitis A, B, or C?

TOBACCO UTILIZATION

□NEVER USED		
□FORMER USER	□<1 MONTH □1-3 MONTHS □3-6 MONTHS □6-12 MONTHS □1-5 YEARS □5-10 YEARS □>10YRS	
□CURRENT USER	□DAILY □SPORADICALLY	□READY TO QUIT □ NOT QUITTING
	FIRST SMOKE IS __________ MINUTES UPON AWAKENING.	
	SMOKES PER DAY: □<5 □6-10 □11-20 □21-30 □≥31	

ALCOHOL CONSUMPTION

□NONE	□1-2 DAYS PER MONTH
□1-2 DAYS PER WEEK	□MOST DAYS
AVERAGE DAILY AMOUNT?	
□ 1-2 DRINKS □3-4 DRINKS	□5 -6 DRINKS □≥6 DRINKS