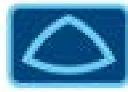


BAPTIST MEDICAL GROUP
GI SPECIALISTS FOUNDATION


Paul S. Bierman, MD
Kenneth I. Fields, MD
Edward S. Friedman, MD
Gerald J. Lieberman, MD
Rande D. Smith, MD

**MAIN OFFICE & SURGERY CENTER**
80 Humphreys, Suite 200
Memphis, TN 38120
**APPOINTMENTS** 901.761.3900

Brighton Office
240 Grandview Drive
Brighton, TN 38011

Collierville Office
1500 W. Poplar
Suite 304
Collierville, TN 38017

Covington Office
1995 Highway 51 South
Suite 106
Covington, TN 38019

Millington Office
7777 Church Street
Millington, TN 38053

Marion Office
1229 Highway 77
Suite 1
Marion, AR 72364


## WELCOME TO GI SPECIALISTS FOUNDATION, INC.

Thank you for choosing GI Specialists. Our physicians and clinical staff are dedicated to providing the highest quality health care for all our patients and to operating our practice under the strictest ethical business standards. Our main office and Baptist GI Lab are located at 80 Humphreys in the Baptist Medical Center. We also have satellite offices in Brighton, Collierville, Covington, Millington and Marion, AR.

While receiving treatment at our clinic, your doctor may decide that a diagnostic test or procedure is medically necessary in order to reach a proper diagnosis of your illness. The majority of our procedures can be done right here in our Suite 200.

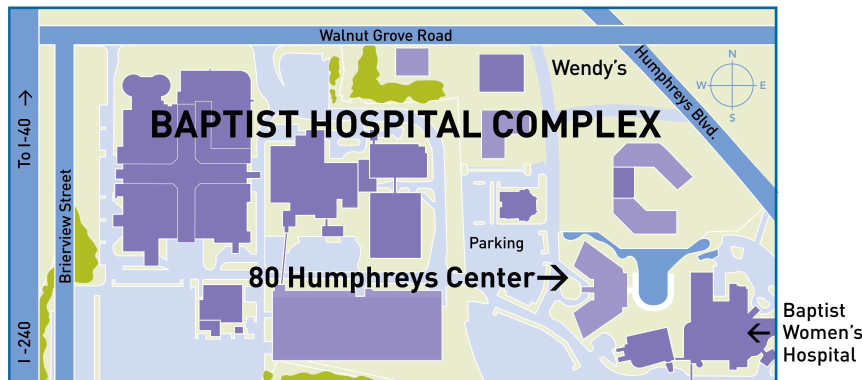
The enclosed packet will provide you with information and some forms we need for you to complete prior to your first visit. The information you give us about your medical history and your current condition will help us to more effectively provide treatment. Completing these forms prior to your first visit will also shorten your wait time.

If you should have any questions prior to your visit, please feel free to call our office at (901) 761-3900 or visit us on the web at gispecialistsmemphis.com.

Sincerely,

*GI Specialists' Physicians and Staff*

For driving directions, please go to
www.gispecialistsmemphis.com/contact.html





80 Humphreys Center, Suite 200 Memphis, TN 38120
901.578.2538 or 901.761.3900 Fax 901.578.2572
www.gispecialistsmemphis.com

BMG | BAPTIST MEDICAL GROUP

# PATIENT REGISTRATION

**MRN**____________________________

Date________________ Referring Physician ______________________________ Primary Care Physician ________________________

Patient Last Name_________________________ First Name _____________________ Middle Initial_____ Suffix _____(Jr/Sr/II etc.)

☐ Male ☐ Female Date of Birth ______/______/______ Soc. Sec. #________________________________

Address ___________________________ City _______________________ State ________Zip ____________ County __________________

Home phone _______________________ Work phone __________________________ext._______ Cell phone _______________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Patient E-mail Address____________________________________

Highest level of education: ☐ GED ☐ High School ☐ BA ☐ BS ☐ Masters ☐ PHD ☐ Other ________________________________

Patient Pharmacy _______________________________________________________Pharmacy Phone _____________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other _____________________________ Need Interpreter? ☐ Yes ☐ No

Ethnic Background: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Other______________________________________________

Race: ☐ Ame. Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White/Not Hispanic ☐ Other ______________________

Employer: ____________________________________ Employer Address ______________________________________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Active Duty Military ☐ Disabled ☐ Student FT/PT

Job Title: ____________________________________________________________________________________________________________

Is this visit due to an accident? ☐ Y ☐ N If yes, explain: ______________________________________ Is this visit job related? ☐ Y ☐ N

Date of injury: ______/______/______ Supervisor name: ____________________________ Phone: ___________________________

**Emergency Contact**

Name____________________________________________ Relationship ______________________ Phone ___________________________

**Responsible Party Information**

Name_________________________________________ Home phone ________________________Cell phone _________________________

Relationship to patient ________________ ☐ Male ☐ Female Date of birth: ______/______/______ Soc. Sec. #____________________

Address _____________________________________ City ____________________________ State ___________Zip __________________

Employer ______________________________________________ Employer Address ___________________________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Active Duty Military ☐ Disabled ☐ Student FT/PT

**Primary Insurance**

Insurance Co. ___________________________________________

Group # _________________Policy # _______________________

Subscriber ______________________________________________

Relationship to Patient: __________________ Date of Birth: ____/____/____

☐ Male ☐ Female Soc. Sec. # __________ Phone __________

Employer _______________________________________________

Address ________________________________________________

______________________________________________________

*Signature of patient or person authorized to sign for patient*

**Secondary Insurance**

Insurance Co. ___________________________________________

Group # _________________Policy # _______________________

Subscriber ______________________________________________

Relationship to Patient: __________________ Date of Birth: ____/____/____

☐ Male ☐ Female Soc. Sec. # __________ Phone __________

Employer _______________________________________________

Address ________________________________________________

Date__________________________

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# AUTHORIZATION TO LEAVE MESSAGES

Patient Last Name________________________ First Name ____________________ Middle Initial_____ Suffix _____(Jr/Sr/II etc.)

Address ____________________________________ City___________________________ State ___________Zip _________________

Date of Birth ______/______/______

Which of the following communications means are appropriate/acceptable for BMG to communicate with you: (please check all that apply)

☐ Home phone # ____________________________ ☐ Okay to leave a message? ☐ Yes ☐ No

☐ Cell phone # ______________________________ ☐ Okay to leave a message? ☐ Yes ☐ No

☐ Work phone # _____________________________ ☐ Okay to leave a message? ☐ Yes ☐ No

---

Which method of communication is preferred? ☐ No contact ☐ Mail ☐ Phone ☐ Email ☐ Mychart

---

With whom may we share information about your health? Please list below.

**Note: In order for BMG to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:**

**1. Last 4 digits patient's social security number 2. Patient's date of birth 3. Patient's zip code**

### AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

| Name | Relationship to You | Telephone Number | May Discuss Diagnosis/Treatment | May Discuss Billing Info |
|---|---|---|---|---|
| ____________ | ____________ | ____________ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ____________ | ____________ | ____________ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ____________ | ____________ | ____________ | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ____________ | ____________ | ____________ | ☐ Yes ☐ No | ☐ Yes ☐ No |

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name ______________________________________________ Relationship to Patient ________________________

Check one: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature:_______________________________________________________ Date: _________________

**OFFICE USE ONLY – Document should be Scanned under Ambulatory Auth and Consent Doc type**

BMG | GI SPECIALISTS FOUNDATION

# Authorizations & Acknowledgments

Date: ___________________ MRN______________________________

Patient Name: ____________________________________________
First Middle Last

**Acknowledgment of Notice of Privacy Practices**

*Initial Here* ________ I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

**General Consent to Treatment and Test**

*Initial Here* ________ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

**Release of Information**

*Initial Here* ________ I authorize Baptist Medical Group to release any medical information necessary to process payment of my claim.

**Assignment of Insurance Benefits and Acceptance of Financial Responsibility**

*Initial Here* ________ I authorize payment directly to Baptist Medical Group for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by Baptist Medical Group and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

**Communication Regarding My Account**

*Initial Here* ________ I agree that the facility, Medical Financial Services, Inc. or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as “collectors”) to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

**Destruction of X-ray Images/Graphic Data (MS Patients Only)**

*Initial Here* ________ I hereby authorize the entity to retire x-ray images and other graphic data which may be generated during my care (treatment, testing, or otherwise) four years after the time generated if a proper report is in the medical record.

_____________________________________________
Signature of patient/parent/guardian/person authorized to sign for patient

Date: __________________

**PLEASE NOTE:** You will receive a separate bill from **BMH-GILAB2**, representing the charges for the procedure (this is called a facility charge). If your insurance requires a co-pay, you will receive a phone call from the surgery center prior to your procedure, asking you to bring your co-pay on the day of the procedure. This payment will be applied to the **BMH-GILAB2** bill. Again, this bill and co-pay is separate from **BMG-GI Specialists Foundation** billing.

# NOTICE TO OUR PATIENTS

During the course of your treatment at BMG, your healthcare provider may recommend you to have procedures performed. Specifically, if you are referred to have radiology or certain other imaging services, such as an MRI, CT or PET scan, we want to provide you with information to ensure you are informed of your rights as our patient.

I. You have the right to receive your healthcare services at the provider of your choice.

II. You have the option to use BMG or an alternate healthcare service provider.

III. You will not be treated differently by your BMG healthcare provider if you choose not to use BMG services.

Below is a list of some alternate healthcare service providers:

**The Flinn Clinic**
1300 Wolf Park Dr.
Germantown, TN 38138

**Diagnostic Imaging PC**
6401 Poplar Ave
Memphis, TN 38119

**Park Avenue Diagnostic**
5190 Park Avenue
Memphis, TN 38119

**Outpatient Diagnostic Center of Memphis**
5130 Stage Rd
Memphis, TN 38134

**Diagnostic Imaging Specialists**
7420 Guthrie Dr. N # 105
Southaven, MS 38671

**Imaging Center**
320 S Gloster St
Tupelo, MS 38804

**Radiology Clinic**
411 Main St S
Amory, MS 38821

**Premier Imaging**
1207 MS-182
Starkville, MS 39759

**Alliance Health Care Services**
581 Medical Drive
Clarksdale, MS 38614

**Imaging Center**
2526 N. 5th Street
Columbus, MS 39705

Please inform your healthcare provider, if you desire to have your procedures performed at a facility other than BMG.

I acknowledge that as a patient of Baptist Medical Group, I have been informed of my rights.

Patient Name (Please Print or Type) ______________________ Date of Service ______________________

Patient Signature ______________________ Date ______________________

Form # 21-100.150 (09/15)

# Baptist Medical Group Inc. (BMG)
## Authorization to Release PHI
## Physician Practices

Baptist Clinic Name:________________________ **Phone #**________________ **Fax#** ____________

Address:____________________________________________________________

PATIENT'S NAME: ____________________ BIRTH DATE:______________ Chart #: __________

ADDRESS: ________________________ Phone #:____________ Last 4 digits of SS #:__________

I authorize Baptist or the following person or organization (specify if applicable) ________________ to:

☐ **disclose** my health information to:________________________________________

________________________________________________________________

*(Name and Address) - Specify: Attorney, Insurance, Self, etc*

☐ **obtain/request** copies of my health information from: ______________________________

________________________________________________________________

*(Name and Address) - Specify: Hospital, Doctor, etc*

Purpose of use, disclosure, and or request: ☐ Continuation of Care/Treatment ☐ Attorney ☐ At the request of the patient ☐ Payment ☐ Other, specify: ______________________________________

I authorize use and/or disclosure of information covering treatment from: ______________ to: ____________
(enter specific dates)

Information to be used and/or disclosed:
☐ History and Physical ☐ Progress Note ☐ Lab ☐ Radiology/Imaging ☐ All records ☐ Itemized bill
☐ Other (Specify): ______________________________________________

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus).

This release will include information I have previously restricted from my health plan unless I initial here. ☐

This authorization will expire one year from the date of your signature unless you specify a different expiration date, event, or condition. Please specify: ______________________________________________

I understand that I have a right to revoke this authorization at any time, except to the extent that release of information has already occurred in reliance on my prior authorization.

I understand that in order to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to the Director of Health Information Management at the Baptist facility indicated above. The revocation document is to contain the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility of benefits purposes, such as workers' compensation, private health insurance, application for insurance, etc., my refusal to sign may effect payment, enrollment or eligibility for benefits. This, in turn, may effect payment for services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

When Baptist **seeks** an authorization for its own use or disclosure of protected health information (e.g., marketing, research, etc.), a **copy** of the authorization is provided to the patient.

______________________________ ______________________________
Date | Patient (or person authorized to consent for minor or patient who is unable to sign)

______________________________ ______________________________
Witness | Relationship and/or authority to act for the patient

Photo ID was provided: Yes ☐ No ☐ If no, specify form of patient identification:________________

BMG
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Rande D. Smith, MD

NAME ______________________________

# MEDICATION LOG

Please complete this form and bring it with you to your first appointment. Help keep us updated on your medications by letting us know when other doctors prescribe medication for you.

| Medication | Dose | Schedule | Prescribing Doctor | Start Date | Medication is for: |
|---|---|---|---|---|---|
| [example] Prilosec | 40 mg | One Daily | Dr. John Smith | 2/05/11 | Fluid Buildup |
| | | | | | |
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GI Specialists Foundation • 80 Humphreys Center • Suite 200 • Memphis, Tennessee 38120 • (901) 761-3900

# Baptist Medical Group Inc. (BMG)

## Cancellations and Missed Appointments (patient info)

Our goal is to provide quality individualized medical care. “Late cancellations” and “No Shows” are barriers for individuals who need access to medical care in a timely manner. *We recognize that certain life events make it difficult to notify us of the need to cancel or reschedule an appointment.* If you must cancel an appointment, please follow the guidelines below.

### Cancellation

In order to be respectful of the medical needs of other patients, please be courteous and notify the clinic when you are unable to show up for a scheduled appointment. We require that you notify the clinic 24 hours in advance. A late cancellation exists when notice to cancel does not occur 24 hours prior to the scheduled appointment time. This timely notification will allow another individual an opportunity to receive treatment. *Failure to cancel a scheduled appointment in a timely manner will be recorded in the medical record.

### How to Cancel Your Appointment

To cancel appointments, please call GI Specialists Foundation at (901)761-3900. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please include a telephone number. A clinic representative will contact you to schedule another appointment that better meets your needs.

If you have signed up for our web-based patient portal, MyChart, you may electronically cancel an appointment; request to reschedule and/or sign up for “FastPass”. Fast Pass is a wait list feature that automatically sends messages via text or email to notify patients of a “wait list” appointment offering. Upon receiving the message, patients can then long in to MyChart and claim the available appointment, decline the appointment offering or simply wait for another offering.

### Missed Appointment / No Show

A *no show* exists if you fail to appear for a scheduled appointment.
*Failure to appear for a scheduled appointment is recorded in the medical record.

- Each missed appointment / no show, will be followed up by a clinic representative.
- Three missed appointments and/or late cancellations may result in fees and/or separation from the clinic.

*Please Note: Missed appointments are reviewed over a 12 month period.

**I do hereby acknowledge that I have received and read the guidelines above and have had any portion of the guidelines which I do not understand explained to me.**

________________________________ __________________

**Patient or Guardian Signature** **Date**