MIDWEST THERAPEUTIC ENDOSCOPY CONSULTANTS

2821 N. Ballas Rd., Suite 110
St. Louis, MO 63131
Phone: 314-628-9000
Fax: 314-994-1997

Date of Visit: _____

Patient Information

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Jr. ❑ Sr.

Patient Name: Last: _____ First: _____ Middle Initial: _____

Preferred Name: _____ Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other

Date of Birth: ____/____/____ Sex: ❑ Male ❑ Female Social Security Number: _____

Race: ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian or other Pacific Island ❑ African American ❑ Caucasian
Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino

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

Address: Street: _____ City: _____ State: _____ Zip: _____

Email: _____ Emergency Contact: _____ Contact Number: _____

Status: ❑ Employed ❑ Unemployed ❑ Retired ❑ Student Highest Level of Education: _____

Employer: _____ Occupation: _____

Address: Street: _____ City: _____ State: _____ Zip: _____

Insurance and Responsibility Party Information

Insurance: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

Insurance: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

HIPAA Communication Preference

In order for our office to better communicate with you, please indicate your preference below:

What is your primary phone contact? ❑ Cell ❑ Home ❑ Work May we send you text messages? ❑ Yes ❑ No

May we leave you a voice mail? ❑ Yes ❑ No May we communicate with you by email? ❑ Yes ❑ No

May we communicate with anyone on your behalf? ❑ Yes ❑ No

Contact Name: _____ Phone #_____

I agree that the information supplied on this form is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Over ⟶

MTEC

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IMPORTANT INFORMATION ABOUT YOUR PHYSICIAN'S CHARGES

Physician charges are for services rendered by the physician for medical care. Prompt payment of these charges is appreciated and helps us to provide medical care for all of our patients at a reasonable cost.

Please remember that insurance is a contract between you and Medicare or your Insurance Company. You are responsible for obtaining referrals when necessary and knowing what hospitals and providers are in your "network". Ultimately it is your responsibility to see that your bill for care rendered by the providers is paid.

All charges noted on your bill from our office reflect fees charged by the physician for services rendered in the office, hospital or surgery center. When you are seen in either the hospital or the surgery center, you may receive additional bills from the hospital or surgery center, which are separate from our statement.

Cancellation Policy

The physicians and staff of Midwest Therapeutic Endoscopy Consultants, LLC appreciate each patient. Our staff works diligently to ensure each patient appointment request is satisfied at a time and location most convenient to the patient. When a patient does not show for their appointment, they not only waste the physicians' time, but also deprive other patients of timely care. With this in mind we have found it necessary to institute a no-show policy. Effective 6/1/08 Midwest Therapeutic Endoscopy Consultants, LLC (MTEC) reserves the right to **charge a $75 fee** to any patient who fails to provide a twenty-four (24) hour notice of an inability to attend an appointment.

Payment Policy

You are responsible for paying any charges not covered by your insurance provider including, but not limited to; charges for co-payments, annual deductibles, non-covered services and services rendered without a required referral from your primary care doctor as well as any collection fees incurred. You should also consult with your insurance provider to confirm the charges for which you are responsible. Charges not covered by your insurance must be paid during the office visit unless other arrangements have been made in advance. All charges are due and payable within fifteen (15) days of the first billing statement.

For your convenience we accept cash, checks, MasterCard, Visa and Discover. A $20 fee plus an amount equal to the actual charge will be added to your account for a dishonored check.

Insurance Information

MEDICARE: Our practice accepts Medicare assignment. We will file Medicare claims and Medicare will pay us directly. If applicable you are responsible for the twenty percent (20%) co-insurance, annual deductible, and any non-covered charges. Please note that some hospitals and surgery centers are NOT accepting some of the Medicare Advantage (PFFS) plans.

COMMERCIAL INSURANCE: We will file claims for your convenience. You are responsible for any co-payments, annual deductible amounts and charges for non-covered services. Co-payments must be made at the time of your visit. If a referral from your primary care doctor is required, you are responsible for obtaining and providing it to us at or before the time of your visit. If you fail to obtain a referral, you will be responsible for all charges. Most insurance Companies will send payment directly to us. In the event our payment is mailed to you, you are responsible for forwarding the payment to us along with any balance due on your account.

MEDICAID: Your Medicaid card must be presented at the time of service. Your are responsible for paying any Medicaid co-pays or spend down amounts. If you have a Medicaid HMO product our office is NOT in network and will require a pre-approval from the HMO as well as a referral from your primary care physician before your appointment or payment in full will be required at the time of your office visit.

Patient signature _____ Date _____

If you have any questions regarding your bill, please ask to speak with our Billing Department. We will work with you on a payment schedule if necessary on any outstanding charges. Thank you for your cooperation.

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Patient History

Date of Visit_____

Patient Name_____ DOB_____

Primary Care Physician_____
Name Address City/Zip

Referring Physician_____
Name Address City/Zip

Other Physician_____
Name Address City/Zip

Reason for Visit_____

Pharmacy_____
Name Address City State/Zip

Pharmacy Phone #_____

Current Medication including over-the-counter medication and herbal medication:

Name	Dose	Frequency	Name	Dose	Frequency

Drug Allergies

_____ Reaction_____ Are you Claustrophobic? ❑ Yes ❑ No
_____ Reaction_____ Allergy to IV Contrast/Dye? ❑ Yes ❑ No
_____ Reaction_____ Allergy to Latex? ❑ Yes ❑ No
_____ Reaction_____ Pacemaker/Defibrillator? ❑ Yes ❑ No
_____ Reaction_____ Seafood Allergy/intolerance? ❑ Yes ❑ No

Previous Surgeries (or procedures)

Surgery	Year	Surgery	Year	Surgery	Year

Habits

Tobacco Use: ❑ Never ❑ Currently How many packs per day? _____ How long? _____
❑ Previous tobacco use How long? _____ Year quit _____ What Kind? _____
How many average packs per day? _____

Alcohol Use: ❑ Yes ❑ Rare ❑ Occasional ❑ Frequent What kind of alcohol? _____
❑ Never How many? _____ Past Use _____

Caffeine Use: ❑ Yes ❑ No What kind?_____ How much/day? _____

Illicit Drug Use: ❑ Yes ❑ No Type/kind?_____

Name_____ Date of Visit_____

Your Medical History

- ❑ Anemia ❑ Now ❑ Past
- ❑ Blood Transfusion When_____
- ❑ Cancer Type_____
  - ❑ Diagnosis date_____
  - ❑ Treatment_____
- ❑ Thyroid
- ❑ Diabetes ❑ Type 1 ❑ Type 2
  Age at Diagnosis_____
- ❑ Arthritis
- ❑ Seizures
- ❑ Stress ❑ Anxiety ❑ Depression
- ❑ Asthma
- ❑ Emphysema/COPD
- ❑ Elevated cholesterol
- ❑ High Blood Pressure
- ❑ Stroke/TIA
- ❑ Blood Clots
  Where_____
  When_____
- ❑ Heart Attack
  When_____
- ❑ Congestive Heart Failure
- ❑ Abnormal Heart Rhythm
- ❑ Heart Valve Disorder
- ❑ Kidney Stones
- ❑ GERD/Reflux
- ❑ Ulcers/Peptic Ulcers
- ❑ Gallstones
- ❑ Gallbladder dysfunction
- ❑ Neuropathy/Restless Leg Syndrome
- ❑ Liver Disease
  - ❑ Hepatitis
  Type_____
  Date of Diagnosis_____
- ❑ Cirrhosis
- ❑ Other_____
- ❑ Immunized:
- ❑ Hep A Date_____
- ❑ Hep B Date_____
- ❑ Pancreatitis
  When_____
- ❑ Irritable Bowel Syndrome
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Celiac Sprue
- ❑ Polyps
  Where_____
- ❑ Diverticulosis
  - ❑ Flare When_____
- ❑ Hemorrhoids
- ❑ Fibromyalgia
- ❑ Migraines

Last Menstrual Period_____
Last Colonoscopy_____
Upper Endoscopy _____
ERCP _____
EUS _____

Family History
Mom/ Dad/Bro/Sis/Your Children

- ❑ Anemia
  Relation_____
- ❑ Arthritis
  Relation_____
- ❑ Thyroid
  Relation_____
- ❑ Diabetes Type_____
  Relation_____
- ❑ High Blood Pressure
  Relation_____
- ❑ Stroke
  Relation_____
- ❑ Heart Attack
  Relation_____
- ❑ Gallbladder Disease
  Relation_____
- ❑ Stomach Ulcers
  Relation_____
- ❑ Irritable Bowel Syndrome
  Relation_____
- ❑ Liver Disease Type_____
  Relation_____
- ❑ Pancreatic Disease Type_____
  Relation_____
- ❑ Colitis
  Relation_____
- ❑ Colon Polyps
  Relation_____
- ❑ Colon Cancer
  Relation_____
  Age at Diagnosis_____
- ❑ Cardiovascular Disease
  Relation_____
- ❑ Other Illnesses (not specified above)
  _____
- ❑ Mother Age_____ Alive?_____
  Cause of Death_____
- ❑ Father Age_____ Alive?_____
  Cause of Death_____
- ❑ Brothers # Alive_____
  # Deceased_____
  Cause of Death_____
- ❑ Sisters # Alive_____
  # Deceased_____
  Cause of Death_____
- ❑ # of Children_____
  Ages_____

These Apply to Me Now

- ❑ Fever ❑ Chills ❑ Sweats
- ❑ Weight loss How much_____
  Time period_____
- ❑ Weight gain How much_____
  Time period_____
- ❑ Fainting Episodes
- ❑ Fatigue
- ❑ Anxiety ❑ Stress ❑ Depression
- ❑ Itching
- ❑ Eye redness/irritation
- ❑ Yellow eyes
- ❑ Yellow Skin
- ❑ Cough ❑ Wheezing ❑ Hoarseness
- ❑ Shortness of Breath
- ❑ Chest Pain ❑ Palpitation
- ❑ Heartburn
- ❑ Nausea ❑ Vomiting
- ❑ Difficulty Swallowing
- ❑ Food Intolerance
- ❑ Excessive bloating ❑ Excessive gas
- ❑ Excessive belching
- ❑ Abdominal pain
  Where_____
- ❑ Regurgitation
- ❑ Loss of Appetite
- ❑ Mouth Sores
- ❑ Abnormal colored stools
- ❑ Bright red ❑ Black ❑ White/tan/gray
- ❑ Constipation
  # of stools per week_____
- ❑ Diarrhea
  # of stools per day_____
- ❑ Laxative use?
  Frequency_____
  Type_____
- ❑ Rectal Bleeding
- ❑ Joint pain ❑ Joint swelling
- ❑ Swelling of hands and/or feet
- ❑ Excessive thirst
- ❑ Excessive urination
- ❑ Change in color of urine
- ❑ Other symptoms (not discussed above)

_____
_____
_____
_____

Other Medical Conditions Not Listed Above:

_____
_____
_____
_____
_____
_____