



*Gastroenterology & Hepatology  
Board Certified*

Timothy T. Brady, M.D.  
James W. Dimitroff, M.D.  
Robert M. McMahon, M.D.  
Sajid H. Ansari, M.D.  
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Marsha J. Schulte, A.P.R.N.  
Charles J. Sigmund, Jr., M.D., Emeritus

Date: \_\_\_\_\_

Dear \_\_\_\_\_:

In order to correctly bill your insurance company, please complete and return the following paperwork as soon as possible.

A return envelope is provided for your convenience.

1. Patient Registration Form, **completed and signed.**
2. Credit Policy – **signed.**
3. Copy of the front and back of your insurance card(s).
4. Copy of the referral from your Primary Care Physician (if required by your insurance).
5. Medicare Lifetime Assignment of Benefits - **signed.** (if applicable)
6. Consent to Release Information. **completed and signed.**

Thank you.

The Billing Department

FORM.NPI

Patient Name		Date of Birth	Age	Social Security #	
Street Address			Sex (please circle one)	Marital Status (circle one)	
City	State	Zip Code		Home Telephone	
Employer Name & Address				Work Phone number	
Referring Doctor & Address					

**PRIMARY INSURANCE INFORMATION**

Insurance Company Name		Copay Amount	Group Name or #	ID #
Insurance Company Claims Address				
City	State	Zip Code		Telephone
Insured's Name		Insured's SSN	Insured's Date of Birth	
Insured's Address			Insured's Relationship to Patient	
Insured's City	State	Zip Code		Telephone
Insured's Employer & Address				

**SECONDARY INSURANCE INFORMATION**

Secondary Insurance Company Name		Copay Amount	Group Name or #	ID #
Insurance Company Claims Address				
City	State	Zip Code		Telephone
Insured's Name		Insured's SSN	Insured's Date of Birth	
Insured's Address			Insured's Relationship to Patient	
Insured's City	State	Zip Code		Telephone
Insured's Employer & Address				

**EMERGENCY CONTACT**

Emergency Contact Name (other than living in your home)	
Address	City, State, Zip
Home Phone	Relationship to Patient

**IMPORTANT INFORMATION/AUTHORIZATION: I hereby authorize direct payment of medical benefits to St Louis Gastroenterology Consultants, P.C. for services rendered. I understand I am financially responsible for any balance not covered by my insurance. I further authorize the office of St. Louis Gastroenterology Consultants, P.C. to release any medical records my Insurance requests for the purpose of processing my medical claims.**

**SIGNED \_\_\_\_\_ DATE \_\_\_\_\_**

**READ & SIGN CREDIT POLICY ON REVERSE SIDE  
PLEASE HAVE ALL INSURANCE CARDS AVAILABLE FOR COPYING**



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**CONSENT TO RELEASE INFORMATION**

**Patient's Name:** \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Yes \_\_\_ No \_\_\_ You may leave a message on my answering machine at my home.

Yes \_\_\_ No \_\_\_ You may leave a message on my voice mail at my work.

I understand that it is my responsibility to provide authorization to St. Louis Gastroenterology Consultants, P.C, in order to release any medical information regarding my care. I hereby authorize St. Louis Gastroenterology Consultants, P.C., to release medical information to the following:

- \_\_\_\_\_ (Spouse)
- \_\_\_\_\_ (Significant other)
- \_\_\_\_\_ (Parent)
- \_\_\_\_\_ (Sibling)
- \_\_\_\_\_ (Friend)
- \_\_\_\_\_ (Employer)
- \_\_\_\_\_ (Other)

By signing this release I am authorizing any employee of St. Louis Gastroenterology to either provide verbal or written information regarding my medical condition to the above named individual(s). This authorization may be cancelled by me at any time upon written notification.

\_\_\_\_\_  
Patient Date

F:GENERAL INFORMATION/FORM Info Release

10012 Kennerly Road – Suite 101 St. Louis, Missouri 63128  
Phone: 314-543-5200 Fax: 314-543-5219 Exchange: 314-868-7700  
Additional office: 1400 Highway 61 in Festus Phone: 636-933-0123

## **ST LOUIS GASTROENTEROLOGY CONSULTANTS, P.C.**

### **IMPORTANT INFORMATION ABOUT YOUR PHYSICIAN'S CHARGES**

Physician charges are for the services rendered by the physician for medical problems. Prompt payment of these charges are appreciated and helps us to maintain reasonable cost of medical care for all of our patients; Payment of co-payments and deductible are due at the time of office visits eliminates costly billing procedures.

Please remember that if you have private medical insurance that insurance is a contract between you and the insurance company you choose. You are responsible for obtaining referrals when necessary and knowing what hospitals and physicians are in your "network". Ultimately it is your responsibility to see that your bill or care rendered by the physician 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.

### **CREDIT POLICY**

A. Late-Payment Fee-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. Applicability of such charges is explained below under the caption entitled "Insurance Information." You should also consult with your insurance provider to confirm the charges for which you are responsible. Payments on any charge not covered by your insurance are expected during the office visit unless other arrangements have been made in advance. However, in any event all charges will be due and payable within fifteen (15) days of the first billing to avoid a late-payment fee. The payment fee will be five percent (5%) of the amount outstanding or twenty-five dollars (\$25), whichever is less. However, the minimum fee of ten dollars (\$10) will always be assessed.

B. Forms of Payment; Charge on Returned Checks. For your convenience we accept cash, checks or MasterCard/Visa. A twenty (\$20) fee plus an amount equal to the actual charges by the back will be added to your account for all dishonored checks.

### **CANCELLATION POLICY**

**St. Louis Gastroenterology Consultants, P.C., reserves the right to charge a fifty dollar (\$50) fee to any patient who fails to provide a twenty-four (24) hours notice of an inability to attend an appointment.**

### **INSURANCE INFORMATION**

A. Medicare. The physicians accept Medicare assignments. Medicare claims will be filed by us, and Medicare will pay us directly. You will be responsible for the twenty percent (20%) co-payment in most cases, annual deductible, and possible non-covered charges.

B. Blue Shield and Other Commercial Insurance. Claims will be filed by us for your convenience. Most insurance Companies will send payment directly to us. In the event our payment is mailed to you, you are responsible for forwarding it to us for payment and any balance due on your account. You will also be responsible for any co-payments, annual deductible amounts and charges for non-covered services.

C. Medicaid. Your Medicaid card must be presented at the time of service. We are not accepting new patients at this time.

D. HMO/PPO. All claims will be processed directly from our office. 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 or you will be responsible for all charges. You are also responsible for all co-payments, deductible amounts and non-covered services at the time of your visit. Co-payments should be paid at the time of your office visit to avoid a late-payment fee.

**Patient signature X \_\_\_\_\_ Date \_\_\_\_\_**

**If you have any questions regarding your bill, please ask to speak with our Billing Department. We are more than willing to work a payment schedule with you if necessary on any outstanding charges. Please call our Billing Department at (314)543-5200. THANK YOU FOR YOUR COOPERATION**



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Screening Waiver

ACCOUNT #: \_\_\_\_\_

PROCEDURE: \_\_\_\_\_

REASON FOR PROCEDURE: \_\_\_\_\_

DATE OF PROCEDURE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

Some insurance carriers will not pay for procedures that they consider “preventative or screening.” The test that you are having on the above date may fall into one of these categories. We encourage you to call your insurance carrier to verify if benefits are allowed for the above procedure. Please sign the statement below and return this form to our office in the enclosed envelope.

I, the undersigned, understand that the procedure that I am scheduled to have performed on the above date may not be covered by my insurance benefits and assume full responsibility for payment of this claim.

\_\_\_\_\_  
(Patient’s signature)

\_\_\_\_\_  
(Date)

FORM.SCREENING



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Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

1. Current medical problem/ reason for today's visit: \_\_\_\_\_

2. List all of your current medications and their dosages (including over the counter medicine):  
\_\_\_\_\_  
\_\_\_\_\_

3. Have you ever had any of the following procedures (lighted tube passed into your mouth or rectum in order to look at your digestive tract):

	Yes	No	List date/place where done:
Upper endoscopy (esophagus/stomach/small intestine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colonoscopy (complete colon exam)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sigmoidoscopy (short colon exam)	<input type="checkbox"/>	<input type="checkbox"/>	_____
ERCP (bile duct, pancreas)	<input type="checkbox"/>	<input type="checkbox"/>	_____

4. Have you ever received a blood transfusion: No  Yes  If yes, date/reason: \_\_\_\_\_

5. Have you previously or do you currently smoke: No  Yes  If yes, packs/day \_\_\_\_\_ Date stopped: \_\_\_\_\_

6. Do you drink alcohol: No  Yes  If yes, amount **per week** \_\_\_\_\_

7. List any known allergies: \_\_\_\_\_ Problems with anesthesia: No  Yes  If yes, date/reason: \_\_\_\_\_

8. Check below, any medical problems that run in your family and indicate relatives:

- Colon Cancer \_\_\_\_\_  Colon polyps \_\_\_\_\_  Polyps \_\_\_\_\_
- Liver disease \_\_\_\_\_  Diabetes \_\_\_\_\_  Ulcer \_\_\_\_\_
- (including cirrhosis)
- Heart disease \_\_\_\_\_  Other \_\_\_\_\_

9. Check below, any medical problems that you now have or have had in the past:

- Difficulty swallowing  Change in appetite  Weight loss  Weight gain
- Heartburn/ indigestion  Nausea/Vomiting  Ulcers  Abdominal pain
- Esophagitis  Tuberculosis  Heart Disease  Kidney Disease
- Emphysema  Black lung disease  Stroke  High blood pressure
- Bleeding problems  Hepatitis  Yellow jaundice  Pancreatitis
- Cirrhosis  Severe itching  Arthritis  Seizures
- Gastrointestinal bleeding  Bloody/Black stools  Diarrhea  Constipation
- Colon polyps  Change in bowel habits  Others \_\_\_\_\_

10. Check below any surgeries you have had and date/place where done:

- Gallbladder \_\_\_\_\_  Pancreas \_\_\_\_\_  Esophagus \_\_\_\_\_
- Stomach or Ulcers \_\_\_\_\_  Liver or bile duct \_\_\_\_\_  Colon / Rectal \_\_\_\_\_
- Small intestine \_\_\_\_\_  Exploratory \_\_\_\_\_  Appendectomy \_\_\_\_\_
- Gynecologic \_\_\_\_\_  Other \_\_\_\_\_