JOB JACOB, M.D. **PATIENT REGISTRATION (please print)**

***Email:_____ Date of Birth:_____/_____/_____

Patient_____
First Middle Last

SS#_____-_____-_____ Married____ Single____ Divorced____ Widowed____ Other_____

Physical address_____City_____State_____Zip_____
(if student, address of parent or responsible party)

Mailing address (if different)_____

Primary Phone(_____)_____ Secondary Phone: (_____)_____

Race_____ Are you of Hispanic/ Latin descent? Yes/ No Primary Language_____

Patient Employer _____Work Phone (_____)_____

Name of physician who referred you _____

Who is your Primary Care Physician? _____

What pharmacy do you use? _____Phone(_____)_____

Have you ever been treated by Dr. Jacob before? Yes _____No_____

Name of Holder of Insurance _____

His /Her Birthdate_____ His/Her Social Security #_____-_____-_____

PRIMARY Insurance Carrier _____ Effective Date _____

ID#_____Group#_____

SECONDARY Insurance Carrier _____Effective Date_____

ID#_____Group#_____

In case of emergency, name of who should be contacted?_____

Phone(_____)_____Relationship_____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and authorize all medical benefits to be made directly to JOB JACOB, MD on my behalf for any services furnished to me by him. I am responsible for all deductibles, co-insurance , copays, and any non covered services. I authorize the use of this signature on all my insurance submissions, electronic or paper.

_____ _____
Signature of Insured or Guardian Date

REVIEWS: I HAVE CAREFULLY REVIEWED THE INFORMATION ABOVE AND IT REMAINS THE SAME

FIRST REVIEW:_____ _____
Responsible Party Signature Date

SECOND REVIEW:_____ _____
Responsible Party Signature Date

THIRD REVIEW:_____ _____
Responsible Party Signature Date

Job Jacob M.D

FINANCIAL POLICY

We are glad you have chosen our clinic. Our primary responsibility is to provide the highest quality medical care to our patients. Please bring your insurance card and a photo identification card to each visit. All co-pays, co-insurance, and deductibles required by your insurance plan for each visit MUST BE PAID AT THE TIME OF YOUR VISIT or when scheduling a procedure. We understand that this may be a hardship for some and we are glad to work with you to establish a reasonable payment plan.

Commercial Health Insurance

Our clinic participates with most Arkansas-based commercial insurance plans and we are glad to file a claim on your behalf as a courtesy to you. However, your contract/ policy with your insurance company is between you and your insurance company, not between our clinic and your insurance. It is your responsibility to know your benefits and policy coverage with your insurance. Our clinic is contracted with Blue Cross Blue Shield, Blue Advantage, Health Advantage, Qual Choice, Amco, Coresource, Cigna, Aetna, Tricare, United Health Care and Humana. If you do not see your insurance listed, please contact your insurance company prior to your visit to verify if our doctor is in your particular network. We will accept out-of-network insurance, but you will be responsible for any charges not covered by your plan.

While we will file claims <u>for</u> you, if a payment is not received from insurance within 30 days, the balance is transferred to you. Therefore, we encourage you to promptly complete all inquiries you may receive from your insurance carrier regarding past coverage, past health conditions, or eligibility of family members. Failure to return insurance inquiries in a timely manner will result in the denial of insurance payment on your claim. This balance will immediately become your responsibility.

If you have a deductible to meet and are going to have a procedure, you will be expected to pay a deposit depending on the procedure scheduled. Any balance owed will be billed to you after the Insurance payment.

If you have received a new insurance card or have changed plans, please provide a copy of your new card to our receptionist. If a claim is denied because it is sent to a terminated plan, the outstanding balance will become your responsibility.

Medicare/ Medicare Advantage Plans

We are participating providers for Medicare and some Medicare Advantage Plans. We will file your primary and secondary insurance. If you do not have a secondary policy, you will be responsible for your 20% coinsurance at the time of your visit. If you have a Medicare Advantage Plan, you will be expected to pay your co-pay or co-insurance at the time of your visit.

Medicaid

We are participating providers with Arkansas Medicaid. All Medicaid patients will be asked to present a Medicaid ID card, a photo ID and a referral. **It is your responsibility to obtain the necessary referral.** Eligibility will be verified prior to each visit. Any services received without the insurance-required referral will be your responsibility. Any visit not paid by Medicaid will become your responsibility.

No Insurance/Self-Pay (Cash Patients)

Cash patients must pay 100% of all office visit fees on the day they are seen. If you require a procedure, 50% of the total fee due must be paid at the time of scheduling. All fees must be paid in cash, by MasterCard, VISA, Discover, or certified funds (money order or bank cashier's check).

Appointments

If you miss a scheduled procedure (EGD or Colonoscopy) you will be billed a **$150.00** fee. **A seventy two (72) hour /three <u>business</u> days advance notice** is required for cancellation of procedures. This allows the facility time to change its staffing schedule if needed and time to notify other patients of a revised procedure time.

Accepted Forms of Payment

We gladly accept cash, MasterCard, VISA and Discover Cards. Personal checks are acceptable with a photo ID, a physical home address (no PO boxes) and a valid phone number. We can NOT accept post-dated checks. There will be a $25 charge on all returned checks. For large balances, we will allow a payment plan after a 50% deposit has been made.

_____ _____

Patient/ Responsible Party Signature Date

GENERAL AUTHORIZATION

I hereby give my authorization for Job Jacob, M.D. and their staff to use or disclose my Protected Health Information (PHI) to carry out treatment, payment or any other health care operations.

I understand that my PHI is as follows: information that is oral or recorded in any form that relates to my past, present, or future physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This protected information could include information that is health care provider created, received from another provider, received from a health plan, insurance company, employer, or any other source, and could include demographic information about me.

I give Job Jacob, M.D. authorization to use or disclose my PHI to other health care providers, group health plans, and business associates to provide for my medical care, treatment an evaluation, the payment of my medical care, treatment, and evaluation and to provide the information for utilization and quality care purposes.

I understand that I have the right to request in writing, to inspect and copy my protected health information. There are a few exceptions to this rule. My health care provider must approve or deny my request within 30 days and in the case of denial, provide me with an explanation of the reason, based on the exceptions outlined by HIPAA. My health care provider may charge a reasonable fee for copying, preparation, and postage, which must be prepaid.

Printed Name Signature

Signature of Personal Representative

Date

I ALSO AUTHORIZE MY PRIMARY CARE PHYSICIAN, REFERRING PHYSICIAN, OR OTHER PREVIOUS PHYSICIANS TO RELEASE ANY RECORDS NECESSARY TO ASSIST DR. JACOB IN MY CARE. THIS INCLUDES OFFICE NOTES, PROCEDURE NOTES, AND COPIES OF PATHOLOGY AND/OR LAB RESULTS. I UNDERSTAND THESE RECORDS MAY BE SENT BY FAX OR MAIL.

Signature of Patient Date

Job Jacob MD

Acknowledgment of Receipt of Notice of Privacy Practices

Dr. Job Jacob provides information on how our practice may use and/or disclose protected health information about you for treatment, payment, health care operations, and disclosures required by law and describe when an authorization is required from you. Your signature below indicates that you have been provided with a copy of the notice of privacy practices to read. If you would like a copy to take home, please ask our receptionist.

_____

Patient Name

_____

Date

_____

Signature of Patient or Legal Representative

If signed by legal representative, relationship to patient:_____

_____

EMPLOYEE USE

Patient refused Notice of Privacy Practices: yes / no

Reason for refusal, if given:_____

Employee signature:_____

SPECIFIC AUTHORIZATION **(HIPAA)**

I hereby give my authorization for Dr. Jacob and staff to use or disclose my Protected Health Information (PHI) to carry out treatment or any other health care operations.
I understand that my PHI is as follows: Information that is oral or recorded in any form that relates to my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.
This PHI could include information that is health care provider created, received from me, received from another provider, received from a health plan, health care clearing house, insurance carrier, employer or any other source, and could include demographic information about me.
I specifically give this health care provider authorization to use or disclose my PHI to the following person(s):

Name: ***Relationship:***

I understand that I have the right to revoke this authorization at any time. I understand that once this information has been disclosed to the third parties, there may not be any safeguards to prevent the third party from further disclosing the PHI. In the event I want to revoke or change this authorization, I may contact Dr. Jacob's office.

Printed Name Signature

Date

Patient History

Reason for visit:_____

List ALL **Allergies**:_____

_____

Are you allergic to **shellfish, iodine, IVP dye, latex, or tape**? N Y If yes, what?_____

****List Medications Below** (this includes **prescription** and **anything over the counter**)**

Medication Name	**Strength (The way it is prescribed)**	**Times per day**	**Length of time taking medication**

List *ALL* surgeries you have had below

SURGERY	YEAR	SURGEON

PATIENTS 65 YEARS OLD AND OVER ONLY:

Have you Had a Pneumonia Vaccine? **Y or N** **When**_____ **Where**_____

Have you had any falls in the past year? **Y or N** if so how many_____ Did it result in an injury? **Y or N**

Do you need antibiotics before having procedures: Y N explain:_____

Patient History

Have you ever had any problems with anesthesia or conscious sedation (such as Demerol, Fentanyl, Versed, or Valium)? N Y explain:_____

Do you have sleep apnea or any other breathing problems? Y N explain:_____

Have you ever been diagnosed with **MRSA** (type of staph infection)? Y N
Do you have/had any type of Hepatitis? Y N if yes, which type A____ B____ C____
Have you ever been treated for Hepatitis? Y N when?_____
Are you a HIV/AIDS carrier? Y N

List the **Year (s)** and what ***Doctor*** if you had any of the following procedures or tests:

Colonoscopy: _____ Flexible Sig.:_____ Upper Endoscopy (EGD):_____

UGI or barium swallow X-Ray:_____ Barium Enema X-Ray:_____

List any other tests (such as CT, MRI, ERCP, etc) that you have had that are **GI-related**:

_____

Alcohol, Drug, and Tobacco History:

Do you or have you ever Smoked? **Yes or No**

If Current or former: What year did you start:_____ **If Former:** Year stopped_____
How many do you smoke daily_____

Smokeless (chew, snuff, etc): Amount Per day_____

Do you drink alcohol? Y or N How often: Monthly Weekly Daily
When you do drink, how many drinks do you have on an average?_____
ever drank 6 or more in one setting: Y or N if so how often Monthly Daily Weekly

Have you used any intravenous or recreational drugs in last 12 months? Y N
if yes, explain:_____

Do you have any tattoos? Y N Have you ever had any blood transfusions? Y N

******Are your parents living or deceased?**_____

Family History:

Has any of your blood relatives had any of the following? Explain the relationship (mother, father, sister, etc)

Colon Cancer Colon Polyps	Y N Y N	Who and what age?
Stomach Cancer	Y N	Who and what age?
Ulcers	Y N	Who and what age?
Liver disease	Y N	Who and what age?
Mental Illness	Y N	Who and what age?
Diabetes	Y N	Who and what age?
Inflammatory Bowel Disease, Crohn's, Ulcerative Colitis	Y N	Who and what age?
Heart Disease, High Blood Pressure, Stroke (**CIRCLE ONE**)	Y N	Who and what age?
Cancer	Y N	***Who*** and **what kind?**

Patient History

CIRCLE ANY OF THE FOLLOWING THAT MAY APPLY TO YOU

GASTROINTESTINAL
Abdominal Pain
Abdominal cramping
Abdominal Mass
Abnormal stool contents/color
Anorexia
Bloody stool
Change in bowel habit
Constipation
Diarrhea
Difficulty swallowing
Fecal Incontinence
Fecal Urgency
Food Intolerance
Gas, Bloating
Gastroparesis
GERD
Hematemesis
Heartburn
Indigestion
Jaundice
Melena
Nausea
Rectal bleeding
Vomiting
Liver Disease
Weight loss/gain

CARDIOVASCULAR
Chest pain
Hypertension
Shortness of breath
Palpitations

RESPIRATORY
Cough
Dyspnea
Asthma
Wheezing

NEUROLOGICAL
Headaches
Syncope
Seizures
Weakness
Dizziness
Stroke

PSYCHIATRIC
Anxiety
Depression
Bipolar
Panic Attacks
Insomnia
Suicidal Ideation
Suicidal Planning

ENDOCRINE
Hypothyroid
Hyperthyroid
Diabetes

HEMATOLOGY
Anemia
Hemochromatosis
Blood clots
Hemophiliac

LIST ANY OTHER SYMPTOMS OR DIAGNOSIS THAT ARE NOT LISTED _____

_____

_____

_____

This form was completed by (circle) Self Other (name)_____

Job Jacob, M.D., PLLC

Board Certified in Gastroenterology

Tel #(501)-513-2628
Fax#(501)-513-2630

Consent to Obtain Prescription History

This consent form authorizes Dr. Job Jacob MD, PLLC to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages. By signing this consent form you agree that Dr. Job Jacob MD PLLC can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes. Understanding all of the above, I hereby provide informed consent to Dr. Job Jacob MD PLLC to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Printed): _____
Patient Date of Birth: _____
Patient Signature: _____
Date of Signing Consent Form: _____