GASTROENTEROLOGY
SOLUTIONS

James E. Cremins, MD | Robinwood Medical Campus | 11110 Medical Campus Road, Suite 242 | Hagerstown, MD 21742

Welcome to Gastroenterology Solutions! Take a moment to review our office and financial policies. Please note, while we participate with most insurance plans, not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits, and provide referrals at the time of your appointment.

* I certify that the information I have provided is correct and I authorize Gastroenterology Solutions to verify insurance coverage and benefits allowed in accordance with my insurance plans coverage.
* I authorize payments be made directly to Gastroenterology Solutions for all medical insurance benefits (including Medicare benefits) which are payable under the terms of my insurance policy for services provided to me or my dependent.
* I authorize Gastroenterology Solutions the use of my Protected Health Information (PHI) to any insurance company, Social Security Administration and Center for Medicare and Medicaid Services or authorized agency, for payment, treatment and/or health care operations.
* I understand that I am responsible for knowing the terms of my insurance plan.
* I am responsible for all fees.
* I understand all charges (co-payments, deductibles, self-pay, etc.) are due at the time professional services are rendered.
* You must provide a copy of your insurance card at each visit.
* For our self-pay patients, we offer a 25% discount for professional services paid in full on the date of service and hospital services paid in full within 30 days of discharge.
* You may be charged a $35 "no show" fee for any appointments missed, not canceled/rescheduled without a 24 hour notice. Multiple "no shows"/cancellations may result in a discharge from our practice.
* Old balances on your account must be paid in full prior to receiving additional services.
* Accounts may be turned over to a collection agency if your account becomes delinquent beyond 60 days. A 25% collection fee will be added to the total balance of the account at the time it is referred. Once the account is placed in collection, the account will also be subject to interest at the rate of 18% monthly. In the event that an account is referred for litigation, all court costs, private process fees and collection costs will be the patients responsibility.
* A service charge of $30.00 will be added for all returned checks. A service charge of $10.00 will be added for co-payments not paid at the time time of your appointment.
* **If you have an insurance plan that requires a REFERRAL, it is your responsibility to obtain proper paper referral prior to your office visit. If you do not have your referral at the time of your appointment, we will hold payment for 24 hours to allow you to obtain your referral.**

We appreciate the opportunity to participate in your healthcare. If you have any questions regarding our policies, please let us know.

By signing below, you acknowledge that you have read, understand and agree to the above policies.

Patient Signature ______________________________

Date: ______________________________

Authorization/Consent to release information and Assignment of Benefits:

Consent for Treatment: I authorize Gastroenterology Solutions to perform examinations, procedures, laboratory tests and to administer such medications as, in his/her opinion, necessary for my care.

Consent for Medication History: I consent to the use of my medication history, from participating medical information changes. By signing, I give permission for Gastroenterology Solutions to obtain formulary information, to check if a prescribed medication is covered, to display therapeutic alternatives, download a historic list of all medications prescribed and information about other prescriptions prescribed by other providers using RXHUB.

Patient Signature ____

Financial Responsibility:

Last Name: ____________________ First Name: ____________________ M.I. ________

Address: ____

____

Social Security # ____

Relationship to Patient: ____

Employer: ____

Employer Address: ____

____

Home #____________________ Cell # ____________________ Work # ____________________

***please circle preferred number to call for communication**

Emergency Contact or Personal Representative Authorized to Access your Protected health information

1. ____

2. ____

In an effort to comply with Meaningful Use measures required by Medicare, please take a moment and answer the following questions:

Marital Status: Married/Divorced/Widowed/Separated/Single

Race: ____________________ Language: ____________________

Ethnicity: ____________________ Email Address: ____________________

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Name: ______________________________ D.O.B. ____________________

Height: _________ Weight: __________ Pharmacy: ____________________________

Primary Care Physician: ____

Past Medical History:

____

____

Past Surgeries:

____

____

Medications:

Allergies:

Check all that apply:

1. Bleeding Disorder	______	11. Stents/Pacemaker/Defibrillator	______
2. Aspirin or Blood Thinner	______	12. Implants/Joint Replacement	______
3. Problems with Anesthesia	______	13. Diabetes	______
4. Sleep Apnea	______	14. Kidney Disease	______
5. Cigarette/Marijuana Use	______	15. History of TIA or stroke	______
6. Latex Allergy	______	16. History of Hypertension	______
7. Recent Steriod Use	______	17. History of Heart Attack	______
8. Breathing Problems	______	18. Recent Weight Loss	______
9. Chest pain with Exercise	______	19. FH Colon Cancer	______
10. Recent cold bronchitis	______	20. Thyroid Problems	

Sign & Date: ____

www.gastrosolutionsmd.com | Phone (240) 382-3783 | Fax (240) 382-3799