New Patient Registration

Last Name:	First Name:	Middle Initial:	
Date of Birth: SSN:	Sex: (Male/Female) Gender at Birth: (Male/Female) Gender Identity: (Male/Female) Sexual Orientation:		
Street Address:		Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	Text: Yes | No
Contact Preference: Home | Cell | Work | Mail | Portal	Hispanic/Latino: Yes | No	Email:	
Marital Status: Married | Single | Divorced | Separated | Widowed | Partner	Language:	Race:	
Occupation:	Employer:	Phone:	
Primary Care Physician:	Preferred Pharmacy: (Name, Street, City, Phone)		
How did you find out about Dr. Malik?			
Emergency Contact:	Relation:	Phone Number:	

Please Fill Out Insurance Policy Holders Information Below (if other than yourself):

Name: _____ Relation: _____

Date of Birth: _____ Address: _____

With whom we may discuss your medical information (non-healthcare providers, family members, friends, etc)?

Name: _____ Name: _____

Relation: _____ Relation: _____

Phone: _____ Phone: _____

Type of Access: ☐ Full ☐ Limited _____ Type of Access: ☐ Full ☐ Limited _____

I hereby authorize Virginia Gastroenterology Institute, PC. to disclose and discuss my protected health information with the persons I have listed on this form. I understand that this consent is voluntary and is not required in order for me to receive treatment. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer be covered by these laws and may be re-disclosed by the recipient. I understand that I may revoke this authorization, except to the extent that action has already been taken, at any time by sending written revocation of authorization to Virginia Gastroenterology Institute, PC.

By signing below, I agree that the above information is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

Form Last Updated: January 2019

Tel: 757.942.2566 • Fax: 855.313.1070
2790 Godwin Blvd, Suite 205, Suffolk, VA 23434-1874 • www.VirginiaGastro.com

Pramod Malik, MD
FACG, FASGE, AGAF, CPI
Board Certified in Gastroenterology

Patient Name: _____ **Date of Birth:** _____

POLICIES AND PROCEDURES AGREEMENT

Financial Policy

- **Patient Information and Insurance Cards:** Please bring a valid photo ID and all health insurance cards with you to each visit. You will be asked to verify your personal and insurance information at each visit. If we are unable to verify your identity and/or insurance coverage prior to services being provided, your account will be set up as uninsured and payment in full will be expected at the time of service, or you will be given the option of rescheduling. It is important that you understand your insurance coverage. Please be sure to check with your carrier or employer regarding your copay, coinsurance, or deductible responsibilities.
- **Insurance Referrals:** Services requiring a referral must have a valid referral on file at our office. Based on your contract with your insurance company, it is your responsibility to ensure you have a valid referral. If we do not have a valid referral your appointment will be rescheduled unless you choose to pay at the time of service.
- **Copays/Coinsurance/Account Balances:** All payments are due at the time of service. Outstanding account balances must be resolved prior to additional services being rendered. I hereby authorize payment of medical benefits that are billed to my insurance to Virginia Gastroenterology Institute PC. I accept responsibility for payment for services provided to me that are not covered by my insurances.
- **Payment for Services for Patients Without Insurance:** You will be responsible for payment by cash, check, or credit card on the day of service. On bills with extensive procedures and with approval from our billing department, you may set up a payment plan with our office. Patients who do not comply with established payment plans or who do not resolve outstanding balances within three statement cycles will be unable to schedule an appointment until the balance is resolved and may be dismissed from the practice.
- **Returned Checks:** There is a **$50.00** fee for any check returned by your bank.
- **Medicare Patients:** I request that payment of authorized Medicare benefits be made on my behalf to Virginia Gastroenterology Institute PC for any services provided to me by their Physicians or Physician Assistants. I authorize release of medical information about me to be released to the Centers for Medicare and Medicaid Services, its agents, and to my insurance company to determine these benefits or the benefits payable for related services.
- **Guarantee of Payment:** I have read and understand all of the policies outlined above. I also understand that any responsibility for payment of medical services in this office for my dependents and myself is mine. Copays are due and payable at the time of service. Any co-insurance and/or deductible due after my insurance company processes claims for services provided is expected within 30 days of the first statement I receive. VGI reserves the right to charge a collection fee of 35% of the principal balance at the time of the write off of dismissal to a third party collection agency.

Appointment Policy

- **Late Policy:** Every effort is made to keep our physicians' schedules on time; therefore, if you are more than **15** minutes late we cannot guarantee that you will be seen immediately, but we will do our best to work you in to the schedule as time permits. If all the providers' schedules are full you may be asked to reschedule your appointment to a later date.
- **Missed/Cancelled Appointments & Procedures:** Every effort is made to accommodate our patients' requests for appointment and procedure dates/times; therefore, it is important that you make every effort to keep your scheduled appointments. No shows and appointments for office visits cancelled within 24 hours will be subject to a fee of **$25**. Cancellation of a scheduled procedure, for any non-medical reason, within 48 hours will also be subject to a cancellation fee of **$100**. To cancel an office visit or procedure please call our office at 757-942-2566. **Please be advised that multiple missed appointments may result in dismissal from our practice.**

Pramod Malik, MD
FACG, FASGE, AGAF, CPI
Board Certified in Gastroenterology

On Call and Emergency Care Policy

- Dr. Malik is the only gastroenterologist at Virginia Gastroenterology Institute at this time. If you have a serious emergency, please proceed to the nearest emergency room or call 911. If it is not an emergency and it can wait, please call us on 757-942-2566 during the normal business hours of 8 am to 5 pm weekdays. Dr. Malik will provide emergency care at Sentara Obici Hospital in Suffolk on days he is on call. He will try his the best to coordinate care on days he is not on call at the hospital. As long as he is reachable by phone through the after-hours service, he will answer only calls of an urgent nature. Medication refills are not done after-hours.

Medical Records Policy

- **Transferring of Records:** All patients must sign a records release form to have their records copied or sent to another provider or organization. Copies will be provided to the patient for a **$10.00** administrative fee PLUS **$0.50** per page up to 50 pages and **$0.25** per page thereafter for paper record. There is no fee to transfer records directly to another provider or organization. All Family Medical Leave Act packets will be provided for a **$25.00** fee.
- **Electronic Medical Records:** In compliance with the United States government mandate to promote the use of electronic medical records, this practice utilizes a securely encrypted electronic prescription and formulary system. I consent to allow this system to retrieve my medication history and formulary information for use in my record.

Medication Policy

- **Prescription Refill Policy:** For all medication refills, please contact your pharmacy to have them request the refills electronically or by fax to 757-932-9279. Please allow 72 hours' notice on all requests. If you have not been seen in our office within the last 12 months, you will be required to been seen in our office before refills will be approved.

Deemed Consent

- **Notice of Deemed Consent to HIV Blood Testing:** A law was enacted in Virginia in 1989 which authorizes healthcare providers to test their patients for HIV antibodies when the healthcare provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the healthcare provider who may have been exposed. However, you will be informed before any of your blood is tested for HIV antibodies pursuant to this provision, the testing will be explained, and you will be given the opportunity to ask any questions you might have.
- **Consent to Treatment:** I hereby authorize Virginia Gastroenterology Institute, PC. to use and/or disclose my health information to carry out my treatment, obtain payment and conduct healthcare operations. I understand this consent is voluntary. I understand that I have the option to choose another healthcare facility for my medical care
- **Images and Videos:** At times images and videos may be used for educational purposes. All media will be anonymous. No patient information shall appear on such media.

Privacy Practices Policy:

- **Notice of Privacy Acknowledgment of Receipt:** I have been informed that Virginia Gastroenterology Institute PC. has a Notice of Privacy Practices, which fully describes how they will use and disclose my health information and that a copy of this is posted in the waiting room and that there are copies available for my review.

By signing this form, I acknowledge and agree to all items listed above.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY FORM

REASON FOR VISIT TODAY: _____

ALLERGIES/REACTIONS – Please list any allergies or reactions to medications, foods, latex or dyes. Please list what type of reaction you experienced (example: difficulty breathing, hives, etc)

MEDICATIONS – Please list all your medications and doses. Include vitamins, herbal supplements and over the counter medications (for example: Ibuprofen, Advil, Aleve, Aspirin, Excedrin, Motrin, etc)

Medication	Dosage	How often taken

FAMILY HISTORY OF CANCER – Please list all family history of cancer known (Colon Cancer, Endometrial Cancer, Bile Duct Cancer, Kidney, Ureter or Bladder Cancer, Pancreatic Cancer, Esophageal Cancer, Liver Cancer, Brain Cancer, etc)

Cancer Type	Relation	Age of onset

SOCIAL HISTORY – Please circle your responses and fill in the blanks where applicable

What is your occupation: _____
Are you able to care for yourself? YES / NO
Circle One: MARRIED / SINGLE / DIVORCED / SEPARATED / WIDOWED / PARTNER
Are you a current smoker: YES / NO → If yes, please list # of Yrs: ____ Packs a day:_____
Are you a former smoker: YES / NO → If yes, please list # of Yrs: ____ Packs a day:_____ Year quit:_____
Do you chew tobacco? YES / NO / Former
Do you drink: YES / RARELY / NO → If yes, please list Amount Per Day _____ OR Amount Per Week _____
Do you currently use recreational drugs? YES / NO
Have you ever used IV drugs? YES / NO
Have you ever been rejected for blood/plasma donation? YES / NO

SURGICAL HISTORY : **Have you ever had a colonoscopy before?** YES / NO **Upper Endoscopy?** YES / NO

Please list ANY surgeries/procedures and **WHEN** (year it was done) and **WHERE** (location and/or doctor):

Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY FORM

PAST MEDICAL HISTORY – Please place a checkmark next to the conditions that you have or have had							
	Anemia		COPD		Hepatitis		Pulmonary Embolism
	Anxiety Disorder		Coronary Artery Disease		HIV		Seizures/Epilepsy
	Arthritis		Depression		Hyperlipidemia		Sleep Apnea
	Asthma		Defibrillator		Hypertension		Stroke
	Barrett's esophagus		Diabetes		Hyperthyroidism		Tuberculosis
	Bleeding Disorder		Dialysis		Hypothyroidism		Ulcerative Colitis
	Cancer- list type in other		Diverticulitis/Diverticulosis		Kidney Disease	**Please list any others:**	
	Cirrhosis		GERD/Reflux		Liver Disease		
	Crohn's Disease		Gallstones		Osteoporosis/Osteopenia		
	Colon Cancer		Heart Attack		Pancreatitis		
	Colon Polyps		Heart Disease		Pacemaker		

REVIEW OF SYSTEMS – Please place a checkmark in the box next to the symptoms you have had recently					
Constitutional		**Gastrointestinal**		**Neurologic**	
	Fever		Difficulty swallowing		Weakness
	Chills		Pain on swallowing		Numbness
	Night Sweats		Indigestion/Heartburn		Memory loss
	Weight gain		Bloating		Headaches
	Weight loss		Belching		Dizziness
	Fatigue		Regurgitation	**Psychiatric**	
Ears/Nose/Mouth/Throat/Eyes			Nausea		Confusion
	Earache		Vomiting		Depression
	Ringing in ears		Decreased appetite		Anxiety
	Loss of hearing		Early satiety		Nervousness
	Nose/Sinus issues		Abdominal pain		Insomnia
	Nosebleeds		Diarrhea	**Endocrine**	
	Snoring		Fecal incontinence		Cold intolerance
	Sore Throat		Constipation		Heat intolerance
	Hoarseness		Blood in stool		Excessive thirst
	Mouth sores		Black or tarry stools		Increase in urinary frequency
	Feeling of foreign body in throat		Intolerance to dairy	**Musculoskeletal**	
	Change in Taste		Pain when defecating		Muscle Aches
	Loss of Vision		Rectal pain		Weakness
Cardiovascular			Rectal bleeding		Joint Pain
	Fainting/lightheadedness		Jaundice	**Hematologic/Lymphatic**	
	Chest pain	**Pulmonary**			Bruising
	Palpitations		Cough		Enlarged lymph nodes
	Arm pain on exertion		Coughing up blood		Excessive bleeding
Genitourinary			Shortness of breath	**Other (please list any others)**	
	Prostate enlargement		Wheezing		
	Blood in urine	**Integumentary**			
	Change in urine appearance		Change in skin color		
	Urine incontinence		Rashes or itching		

Signature: It is extremely important that all medical information is disclosed to ensure your complete evaluation. I certify the information on this form is both accurate and complete to the best of my knowledge. No information has been withheld or omitted concerning my past and present state of health.

Signature of patient or guardian:	**Date:**

Form Last Updated: August 2017