

Thank you for choosing **GastroIntestinal Specialists (GIS)** and **Shreveport Endoscopy Center (SEC)** for your healthcare needs. We appreciate the trust you've placed in us and are committed to providing high-quality, compassionate care.

GastroIntestinal Specialists (GIS) is a professional medical practice specializing in the diagnosis and treatment of diseases affecting the esophagus, stomach, small and large intestines, liver, and pancreas.

Our physicians are board-certified gastroenterologists dedicated to delivering expert care.

Shreveport Endoscopy Center (SEC) is a state-licensed, Medicare-approved ambulatory surgery center, fully accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). The facility is owned and operated by the physicians of GIS and is designed for diagnostic procedures such as EGD (gastroscopy), esophageal dilation sigmoidoscopy, and colonoscopy.

At GIS, we take a collaborative approach to care. You may be seen by one of our skilled **Nurse Practitioners (NPs)** or **Physician Assistants (PAs)** during your visit. These professionals work closely with our physicians and are trained extensively in gastrointestinal conditions and treatment protocols.

Even if you do not meet directly with your physician during your appointment, rest assured that all assessments and care decisions involve physician oversight.

GIS is built on trust, quality care, and a commitment to excellence, and that commitment never wavers.

If you are scheduled for a procedure at SEC, you will receive **separate statements** for services:

- **GIS:** Professional fee (physician services)
- **SEC:** Facility fee (medications, equipment, supplies)
- **Pathology:** If biopsies are performed
- **Anesthesia:** Billed separately by **Shreveport Sedation Associates, LLC**

We will bill your insurance or Medicare for all services rendered. GIS accepts Medicare assignment and participates in most insurance networks. Please be prepared to pay your **co-pay or estimated patient responsibility** at the time of service.

As a patient at SEC, you have specific rights and responsibilities. Because the procedures performed at SEC are elective and of minimal risk, we **do not honor advance directives (such as Do Not Resuscitate orders)** within our facility.

In the event of a life-threatening emergency, we will transfer you to an acute care hospital for further treatment. If you have questions or concerns about this policy, please speak with your physician or a member of our administrative team.

We are always striving to improve and deliver the highest standard of care. If you have concerns about your experience, we encourage you to speak with a supervisor or request a feedback form from a staff member.

All comments and complaints will be reviewed, investigated, and addressed promptly. Your input is vital to our continuous quality improvement efforts.

We are honored to be part of your healthcare journey. On behalf of our physicians and staff, thank you for choosing GIS and SEC. We look forward to assisting you with your medical care.

PLEASE PRINT CLEARLY



Patient Name	SSN	Date of Birth	Age	Gender ☐ Female ☐ Male
Mailing/Street Address		City, State, Zip Code		
Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Greek ☐ Hispanic ☐ Indian ☐ Multi-Racial ☐ Native Hawaiian or other Pacific Islander ☐ White				Ethnicity ☐ Hispanic ☐ Non-Hispanic
Marital Status ☐ Divorced ☐ Married ☐ Single ☐ Separated ☐ Widowed		Primary Care Physician	Referring Physician	
Home Phone Number ()	Day Phone Number ()	Cell Phone Number ()	Email Address	
Patient's Employer Name	Employer Address	City, State, Zip Code		
Spouse or Parent's Name	Home Phone Number ()	Street Address	City, State, Zip Code	
Spouse or Parent's Employer	Business Phone Number ()	Emergency Contact	Phone Number ()	

**IMPORTANT! PLEASE READ CAREFULLY.
INSURANCE AUTHORIZATION AND ASSIGNMENT AND/OR MEDICAL RELEASE.**

I hereby authorize Gastrointestinal Specialists, A.M.C. to furnish any information or to obtain any information from any insurance carrier, physician, attorney, employer, hospital, other health care provider, Louisiana Research Center, or any affiliated entity concerning my medical history, illness and treatments. I hereby assign Gastrointestinal Specialists, A.M.C. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____ Signature _____

Name of Primary Insurance Company		Effective Date of Policy
Insurance Company's Address, City, State, Zip Code		Phone Number ()
Insured's Name	Insured Date of Birth	SSN
Policy Number	Contract Number	Group Number
Name of Secondary Insurance Company		Effective Date of Policy
Insurance Company's Address, City, State, Zip Code		Phone Number ()
Insured's Name	Insured Date of Birth	SSN
Policy Number	Contract Number	Group Number

AUTHORIZATION

All the personnel at GastroIntestinal Specialists, A.M.C., Shreveport Endoscopy Center, A.M.C., and Louisiana Research Center, L.L.C., take your medical confidentiality very seriously. We will not and cannot release information without your written authorization. You have two options.

Option 1 Designate up to two people that we are allowed to speak with. This authorization form, when completed and signed by you, allows our staff members to speak only with an individual or individuals you designate in the event that you are not available to receive our phone calls, or you have an adult family member that helps coordinate your medical care. You should **not** designate yourself or a physician.

If you feel, for example, comfortable allowing us to talk with another person regarding your medical care, you would want to check that box. Please check all the boxes that apply to your needs. If there is another person you wish to authorize, please complete the next section as you did the first.

I authorize employees of GastroIntestinal Specialists, A.M.C., Shreveport Endoscopy Center, A.M.C., and/or Louisiana Research Center, L.L.C., to speak with:

Name (above)	Name (above)
Phone Number (above)	Phone Number (above)
☐ Appointments ☐ Account/Bill ☐ Medical Care	☐ Appointments ☐ Account/Bill ☐ Medical Care

Option 2 If you do not want anyone other than you or your physician to receive your information you will check the box below and sign this form.

☐ I do not authorize anyone to receive information regarding my medical care.

Patient's Signature

Date

Patient's Printed Name

.....
REVOCATION SECTION

I hereby revoke the above authorization.

Patient's Signature

Date

Patient's Printed Name



Date: _____

Name: _____ Age: _____ Gender: _____ Race: _____

Have you ever been seen by a physician in our practice? Yes No If Yes, when _____

Which physician are you scheduled to see today? _____

Which physician referred you to our office for consultation? _____

Who is your primary care physician? _____

PRESENTING COMPLAINT Briefly describe the reason for your visit.

REVIEW OF SYSTEMS Please check any symptoms you are **currently** experiencing.

DIGESTIVE TRACT

- ☐ Nausea/vomiting
- ☐ Trouble swallowing
- ☐ Painful swallowing
- ☐ Heartburn
- ☐ Indigestion/belching
- ☐ Abdominal pain
- ☐ Bloating/gas
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Fecal incontinence
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Rectal pain/itching

GENERAL

- ☐ Change in appetite
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Weight loss _____ lbs
- ☐ Weight gain _____ lbs

BLOOD

- ☐ Anemia
- ☐ Blood transfusion
- Date: _____
- ☐ Easy bleeding/bruising
- ☐ Enlarged lymph nodes

HEART/LUNGS

- ☐ Cough
- ☐ Coughing blood
- ☐ Sputum production
- ☐ Wheezing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling in legs
- ☐ Heart murmur
- ☐ Palpitations

SKIN

- ☐ Itching
- ☐ Jaundice
- ☐ Lesions
- ☐ Rash

HEALTHCARE MAINTENANCE

If you are **45** years of age or older, have you had the following?

- | | | | |
|--|------------------------------|-----------------------------|-------------|
| Colonoscopy | ☐ Yes | ☐ No | Date: _____ |
| Flexible Sigmoidoscopy | ☐ Yes | ☐ No | Date: _____ |
| Cologuard | ☐ Yes | ☐ No | Date: _____ |
| Hemoccult stool test | ☐ Yes | ☐ No | Date: _____ |
| Have you ever had an upper GI series or gastroscopy? | ☐ Yes | ☐ No | Date: _____ |

Have you had the following vaccinations:

- | | | | |
|-----------------|------------------------------|-----------------------------|-------------|
| Influenza (Flu) | ☐ Yes | ☐ No | Date: _____ |
| Pneumococcal | ☐ Yes | ☐ No | Date: _____ |
| Hepatitis A | ☐ Yes | ☐ No | Date: _____ |
| Hepatitis B | ☐ Yes | ☐ No | Date: _____ |



Name: _____

Date: _____

PAST MEDICAL HISTORY Please check the following medical conditions which apply to **you**.

- | | | |
|--|--|-------------|
| ☐ Colon polyps | ☐ High blood pressure | |
| ☐ GERD | ☐ Sleep apnea | |
| ☐ Barrett's esophagus | ☐ Asthma | |
| ☐ Blood thinner | ☐ Seizures | |
| Type: _____ | ☐ Cancer | Type: _____ |
| ☐ Heart problems | ☐ Thyroid problems | |
| ☐ AFib | ☐ Diabetes | |
| ☐ CHF | ☐ High cholesterol | |
| ☐ Stents | ☐ Kidney disease | |
| ☐ Stroke | ☐ Hepatitis | Type: _____ |
| ☐ COPD | ☐ Other | _____ |

PAST SURGICAL HISTORY Please check the following surgeries that **you** have had in the past.

- | | <u>Date</u> | | <u>Date</u> |
|--|-------------|--|-------------|
| ☐ Cholecystectomy (Gallbladder removal) | _____ | ☐ Cancer | _____ |
| ☐ Colon Surgery | _____ | ☐ Bariatric (weight loss surgery) | _____ |
| ☐ Appendectomy | _____ | ☐ Type: ☐ Lap band | _____ |
| ☐ Cancer | _____ | ☐ Gastric sleeve | _____ |
| ☐ Diverticular disease | _____ | ☐ RYGB | _____ |
| ☐ IBD (Crohn's, Ulcerative Colitis) | _____ | ☐ Other _____ | _____ |
| ☐ Bleeding | _____ | ☐ Other _____ | _____ |
| ☐ Obstruction | _____ | ☐ Pancreatic Surgery | _____ |
| ☐ Perforation | _____ | ☐ Liver Surgery | _____ |
| ☐ Hemorrhoidectomy | _____ | ☐ Other GI Surgery _____ | _____ |
| ☐ Other _____ | _____ | | _____ |
| ☐ Stomach Surgery | _____ | ☐ Hysterectomy | _____ |
| ☐ Lap Nissen | _____ | ☐ C-Section | _____ |
| ☐ Ulcer disease | _____ | | |



Name: _____

Date: _____

FAMILY HISTORY

☐ Patient is adopted. Family history unknown.

Father's Age _____ If deceased, age at death and cause _____

Mother's Age _____ If deceased, age at death and cause _____

Total number of brothers and sisters you have had _____

Do you have any **immediate family members (parents, siblings, or children)** that have ever had the following:

☐	Colon Polyps	Relative: _____	Age at Diagnosis: _____
☐	Colon Cancer	Relative: _____	Age at Diagnosis: _____
☐	Liver Disease	Relative: _____	Age at Diagnosis: _____
☐	Diabetes	Relative: _____	Age at Diagnosis: _____
☐	Heart Disease	Relative: _____	Type of Heart Disease: _____
☐	Other Cancers	Relative: _____	Type of Cancer: _____
☐		Relative: _____	Type of Cancer: _____
☐	Other Illnesses	Relative: _____	Type of Illness: _____
		Relative: _____	Type of Illness: _____

SOCIAL HISTORY

What city do you live in? _____

What is your occupation? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children: _____

Do you smoke or chew tobacco? ☐ Yes ☐ No ☐ Former ☐ Social

How many years? _____

Packs per day? _____

Do you vape? ☐ Yes ☐ No ☒ Former

Do you drink alcohol? ☐ Yes ☐ No ☐ Former ☐ Social

Number of drinks? _____

Have you ever used illicit or intravenous drugs? _____

Do you use medical or recreational marijuana? _____

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

SHREVEPORT ENDOSCOPY CENTER, A.M.C. has adopted the following policies regarding Patients' Rights and Responsibilities:

You have the Right to:

1. Considerate and respectful care at all times in a safe setting free from abuse or harassment.
2. Treatment without discrimination as to race, color, religion, sex, national origin, source of payment, political belief, or handicap.
3. Privacy to the extent consistent with appropriate medical care. Case discussions, consultations, examinations, and treatments are confidential and will be conducted discreetly.
4. Confidentiality of medical records and disclosures and the opportunity to approve or refuse their release, except when release is required by law.
5. Know the names and credentials of health care professionals that treat you.
6. Know that a physician may be reached for after-hours and emergency care by calling the local office number, 318-631-9121, or 1-800-925-2132.
7. Receive information, in terms you can understand, concerning your diagnosis, treatment, evaluation and prognosis. When it is medically inadvisable to give such information to a patient, it will be provided to a person delegated by the patient or to a legally authorized person or surrogate.
8. Be fully informed about a treatment or procedure and the expected outcome before it is performed. Participate in decisions involving your health care, except when such participation is contraindicated for medical reasons. Refuse treatment as permitted by law.
9. Know the services customarily rendered by the facility.
10. Be informed by a medical staff member of any continuing health care requirements following discharge. You may have a designee assigned to receive this information.
11. Receive an itemized explanation of all fees for services, regardless of source of payment, by calling the billing office at the main telephone number, 318-631-9121.
12. An interpreter or use of alternative communication techniques/aids as needed.
13. Know that this facility does not honor advance directives. Information you give to staff regarding an advance directive you have in place will be forwarded with your medical chart in the event you must be transferred to another facility. Information and forms regarding advance directives may be found at www.caringinfo.org on the Internet.
14. Change your provider if other qualified providers are available.
15. Refuse to participate in research. Research affecting care or treatment shall be performed only with your informed consent.
16. Know the facility's rules and regulations that apply to your conduct as a patient.

(OVER)

17. If having a procedure, you may choose any of the facilities in which our physicians have privileges.
18. Know that the physicians of GastroIntestinal Specialists have a financial interest in the Center. If you have any questions about this relationship, please feel free to discuss it with us.

You have the Responsibility to:

1. Keep the appointment made for you or, when unable to do so for any reason, notify the Center as soon as possible.
2. Provide complete and accurate information regarding your current health status, medical history and all medications you take including over-the-counter products and supplements.
3. Be accompanied by a responsible adult to drive you home after a procedure and assume your care upon leaving our facility. You cannot leave unaccompanied or by taxi or public transportation.
4. Follow the treatment plan prescribed by your provider. Notify the staff if you do not understand and ask any questions you might have concerning your health care. Report unexpected changes in your condition to the responsible practitioner.
5. Observe the rules and regulations of the Center. Be considerate of other patients and facility personnel.
6. Pay for services rendered in a timely manner.
7. Notify the Administrator of the Center if you have suggestions, complaints, or feel your privacy or safety have been violated. You will be notified in writing of the resolution within 14 days.

Administrator
3217 Mabel Street
Shreveport, LA 71103

PH: 318-631-9121
FAX: 318-631-9126

8. File a grievance within 30 days of the occurrence if you feel your rights have been violated, with the Office of Medicare Beneficiary Ombudsman

1-800-MEDICARE (1-800-633-4227)
Centers for Medicare & Medicaid Services
7500 Century Boulevard
Baltimore, MD 21244-1850
<http://www.medicare.gov/Ombudsman/activities.asp>

TTY: 1-877-486-2048

9. File a grievance with the LA Department of Health and Hospitals if you have a complaint

Health Standards Section
P. O. Box 3767
Baton Rouge, LA 70821

PH: 225-342-0138

10. File a quality of care complaint to eQHealth Solutions, Inc.

8591 United Plaza Blvd., Suite 270
Baton Rouge, LA 70809
<http://louisianaqio.eqhs.org/>

PH: 225-926-6353

