Franklin Gastroenterology, PLLC
Wilmot C. Burch, Jr, MD
740 Cool Springs Blvd, Suite 210
Franklin, TN 37067
615-771-8786 (phone)
615-771-2801 (fax)

We would like to welcome you to Franklin Gastroenterology!

Your appointment date and time is:

Please arrive **30 minutes** before your appointment time to allow time to finish appropriate paperwork and to create a chart for your visit. Please bring your insurance card, picture UD, as well as, your medication list ore medications. This visit is a consultation or initial exam, as a rule there are no procedures done the first visit. **If your insurance requires that you have a referral prior to seeing a specialist, you will need to contact your primary care physician to have that referral sent to us. We will need to have this referral prior to your scheduled appointment.**

Please be advised, depending on your insurance plan, a copay will be collected at the time of service. For any NEW self-pay patients, there is a minimum of **$150.00 deposit** that will be collected at the time of service. We will apply a self-pay discount to that visit and any remaining charges will be invoiced to the patient. For any ESTABLISHED self-pay patient, there will be a minimum of **$75.00** collected at the time of service that will serve as a deposit toward remaining charges that will then be invoiced to the patient at a later date. Again there will be a 20% self-pay discount applied to any remaining charges and this will be billed to you.

Please complete these forms in their entirety; we will collect them from you at the time of service. We also have a patient portal that you are invited to use. If you would like access to this prior to your appointment, please call our office and provide a valid email address. Portal access can be found on our website at www.franklingastroenterology.com.

We will make every attempt to see you on time, acknowledging the fact that emergent situations do occur.

Franklin Gastroenterology does respect your time. Please respect ours as well. If you are unable to keep your scheduled appointment please call our office at least 24 hours in advance as there are other people who would be able to use that time. Failure to contact our office within a timely manner will result in a **$50.00 No Show charge** for NEW patients and a **$25.00 No Show charge** for ESTABLISHED patients.

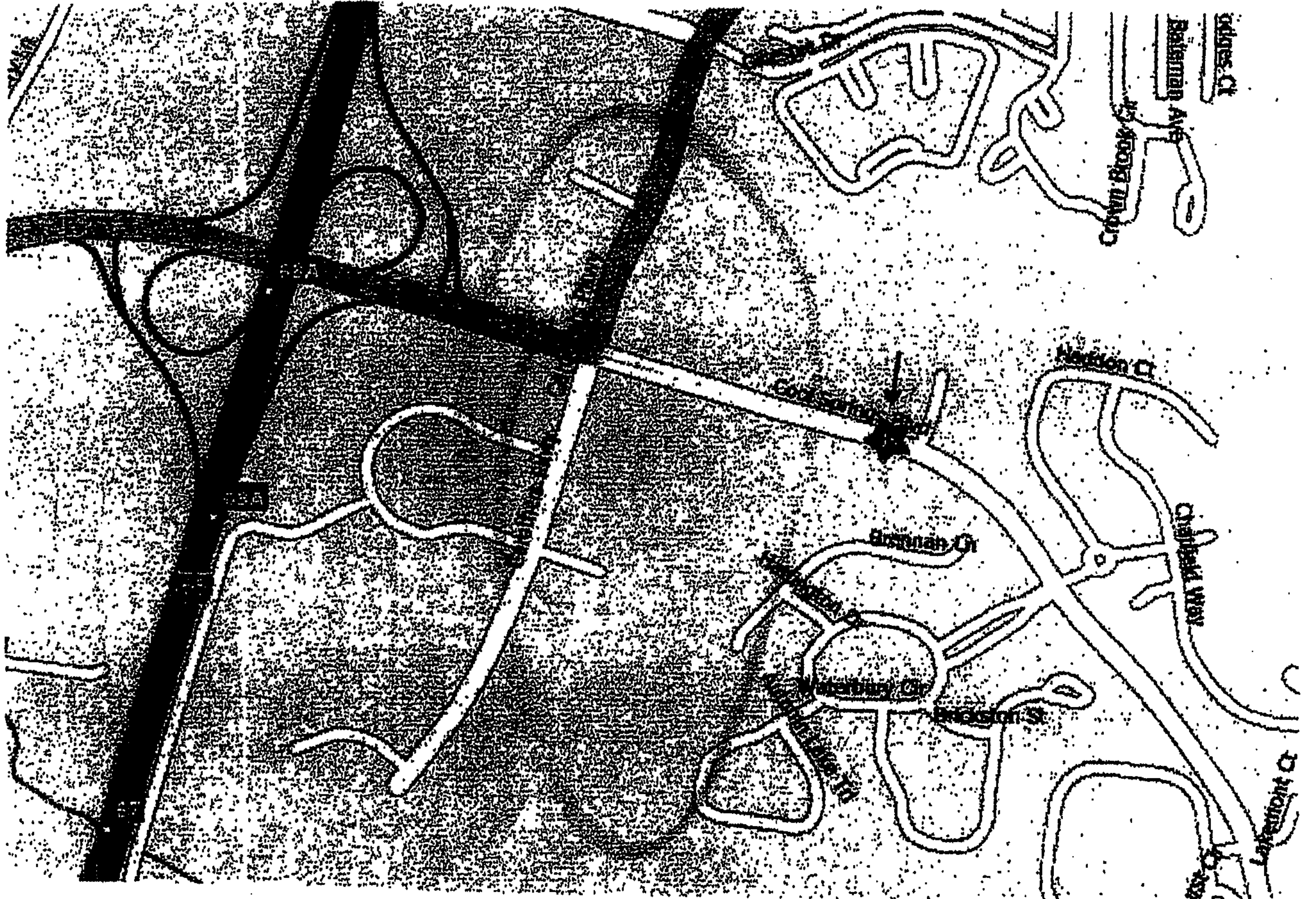
Thank you and we look forward to participating in your medical care.

Sincerely,

Franklin Gastroenterology, PLLC

FRANKLIN GASTROENTEROLOGY; PLLC

740 COOL SPRINGS BLVD. STE 210
FRANKLIN, TN. 37067
PHONE: 1-615-771-8786
FAX: 1-615-771-2801



We are conveniently located off I-65 at exit 68A. Travel Eastbound on Cool Springs Blvd. crossing Carothers Pkwy. Physicians Plaza of Cool Springs is a two story brick Building on the left. Turn left onto Billingsly Ct. and left again into our parking lot. Our office is located on the second floor; Suite 210.

Note: This facility is the last commercial Building on the left.

PATIENT INFORMATION

Name: ______________________________ Date: ____________________ Sex: □ Male □Female

Address: ______________________________ City,State & ZipCode: ____________________________

Home Phone: _______________________ Cell: ______________________ Contact preference: □Home □Cell

Email: ___________________________ SSN #: ___________________ DOB: _________________

Pharmacy Name & Address: ______________________________________ Race: _________ Ethicity: ___________

Employer Name: ____ □Retired □FT Student □PT Student

Referring Physician: _________________________ Primary Care Physician _________________________

Emergency contact name: _________________________ Relationship to you: ____________________

Emergency contact phone number: _________________________

BILLING AND INSURANCE INFORMATION

Guarantor (person responsible for bills): ____

Primary Insurance: _________________________ ID#: _________________________ Group: ______________

Subscriber Name: ______________________________________ Relationship to insured: Self Child Spouse

Subscriber Date of Birth: _______________ Gender: _____Male _____Female

Secondary Insurance: _____________________ ID#: ______________________________

Is policy holder spouse? _____Yes _____No Date of birth: ____________________

PLEASE INITIAL THE FOLLOWING:

_______ **I hereby authorize** Wilmot C. Burch, MD and/or Franklin Surgery Center to furnish my insurance company any/all information which said insurance company(s) may request.

_______ **I hereby assign** Wilmot C. Burch, MD and/or Franklin Surgery Center all money to which I am entitled for Medical and or Surgical expenses relative to the service rendered.**I understand that I am financially responsible to** Wilmot C. Burch, MD and/or Franklin Surgery Center for charges **NOT** covered by this assignment, meaning services **NOT** covered by my insurance company.

_______ **I understand that if I cannot pay my balance in full, I can set up a payment plan or apply for Care Credit.**

DELINQUENT ACCOUNTS: We review past due accounts at every statement cycle. Your communication and involvement to ensure your balance is paid in a timely fashion is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty(60) days past due, further steps to collect this debt may be taken . If you fail to pay on time we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to Premier Radiology and its agents, assignees, and contrractors(which may include third party debt collectors for past due obligations)(1) to contact me by phone or at any number associated with me, if provided by me or another person on my behalf ;(2) to leave messages for me and include in any such messages amounts owed me;(3) to send me text messages or emails using any email I provided or any phone number associated with me, if provided by me or another person on my behalf; and(4)to use prerecorded/artificial voice messages and/or an automated telephone dialing system(auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consumer described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services. **PATIENT SIGNATURE:** ______________________________ **Date:** ____/____/________

Release Of Medical Information

NAME *(Please print)*: ______________________________ DOB: ____________

By Signing Below, I Authorize AdvancedHEALTH To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	______________________
CHILDREN	☐ YES	☐ NO	______________________
IN-LAWS	☐ YES	☐ NO	______________________
CAREGIVERS	☐ YES	☐ NO	______________________
PARENTS	☐ YES	☐ NO	______________________

OTHERS ______________________________

PATIENT SIGNATURE ______________________________ DATE ____________

PARENT SIGNATURE ______________________________ DATE ____________

We ask that if you have any change in this request, that you please inform the receptionist.

AdvancedHEALTH may leave appointment information on my voicemail:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE ______________________________ DATE ____________

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	______________________
RELATIVE	☐ YES	☐ NO	______________________
CAREGIVER	☐ YES	☐ NO	______________________

PATIENT SIGNATURE ______________________________ DATE ____________

We charge a $20 flat rate for 1-5 pages plus .50 per additional page and postage.

I understand that AdvancedHEALTH will ask for identification of the person picking up patient medical information or products.

AdvancedHEALTH

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _______ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: ____

Signature of Patient: ____________________________________ Date: __________

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: ____________________

Relationship: ______________________________ Telephone: ______________

Address: ____

Signature of the above: ______________________ Date: __________ Time: __________

Signature of Witness: ______________________________ Date: __________

AdvancedHEALTH

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: ______________________________

Signature: ______________________________

Date: ______________________________

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: ______________ Initials: ______________

Reason: ______________________________

____

AdvancedHEALTH

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)*

A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

__________ Initials

Patient and/or Debtor Signature: ______________________________ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

AdvancedHEALTH

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on ______/______/________. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: ______________________________ Date: _____/_____/_____

Attorney Name: ____ Phone: ______________________________

BILLING INFORMATION

STATEMENTS:
A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS:
We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non emergency treatment for any and all debtor-related unpaid account balances.

WAIVER OF CONFIDENTIALITY:
You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:
You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. If the request is for a party other than the originally billed insurance and/or party, a **$20.00 medical records fee** will be required on each occasion.

AdvancedHEALTH

Franklin Gastroenterology, PLLC

Patient Name: ______________________ Date of Birth: ______________________

Emergency Contact: ______________________ Phone Number: ______________________

Health Information

Chief complaint: ______________________

Other Active Medical Problems:

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

Medication Allergies or Reactions ______________________

Explain: ______________________

Other Known Allergies: ______________________

Present Medications:

1. ______________ 3. ______________ 5. ______________

2. ______________ 4. ______________ 6. ______________

Frequently Used Non-Prescription Medications:

Aspirin: __________ How Much: __________ How Often: __________

Laxatives: __________ How Much: __________ How Often: __________

Other: __________ How Much: __________ How Often: __________

Do you eat sugarless mints, candy or chew gum? ______________________

Do you drink milk or eat dairy products? ______________________

Previous Hospitalizations/Surgery (Please List All):

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

Have you ever had a blood transfusion? ______Yes ______No; Most recent date : ______________

Franklin Gastroenterology, PLLC
Family History

Mother: Alive: Yes ______No ______; Age/Cause of Death: ______________________________
Father: Alive: Yes ______ No _______; Age/Cause of Death: ______________________________

Please list the number of Brothers, Sisters and Children in each Category Below:
Brothers: Alive: Yes ______No ______; Age/Cause of Death: ______________________________
Sisters: Alive: Yes _____No ________; Age/ Cause of Death: ______________________________
Children: Alive: Yes ______No ________; Age/Cause of Death: ____________________________

Do any diseases "Run In Your Family"? Please explain:
____

Social History

Do you smoke? Yes _____No _____; If so: how much/how often? ____________________________
Do you drink? Yes ______No _____; If so: how much/how often? ____________________________
Any history of HIV+ or AIDS? Yes ______ No _______
Any history of Tuberculosis (positive skin test of exposure)? Yes ______ No _______

Current Medical Condition

Please check appropriate response and briefly explain "yes" responses.

Constitutional Symptoms

Fever	Yes _____	No ____	____________________
Weight Loss	Yes _____	No ____	____________________
Weight Gain	Yes _____	No ____	____________________
Night Sweats	Yes _____	No ____	____________________

Eyes

Trouble with vision	Yes _____	No ____	____________________
Dry Eyes	Yes _____	No ____	____________________
Excessive Tearing	Yes _____	No ____	____________________

Ear, Nose, Mouth and Throat

Trouble with hearing	Yes _____	No ____	____________________
Tinnitus (ringing in ears)	Yes _____	No ____	____________________
Epistaxis (nosebleeds)	Yes _____	No ____	____________________
Trouble with smell	Yes _____	No ____	____________________
Problems with bad breath	Yes _____	No ____	____________________
Trouble with taste	Yes _____	No ____	____________________
Mouth Ulcers	Yes _____	No ____	____________________

Franklin Gastroenterology, PLLC

Ear, Nose and Throat (con't)

Frequent Sore Throat	Yes ____	No ____	________
Hoarseness	Yes ____	No ____	________
Lump in Throat	Yes ____	No ____	________

Cardiovascular

High blood pressure	Yes ____	No ____	________
Heart Murmur	Yes ____	No ____	________
Chest Pains.	Yes ____	No ____	________
Palpitations	Yes ____	No ____	________
Ankle Swelling	Yes ____	No ____	________

Respiratory

Asthma or wheezing	Yes ____	No ____	________
Shortness of Breath	Yes ____	No ____	________
Chronic Cough (>3 weeks)	Yes ____	No ____	________
Blood sputum	Yes ____	No ____	________
Exposure to TB	Yes ____	No ____	________

Gastrointestinal

Constipation	Yes ____	No ____	________
Diarrhea	Yes ____	No ____	________
Rectal bleeding	Yes ____	No ____	________
Black Tarry stools	Yes ____	No ____	________
Change in bowel habits	Yes ____	No ____	________
Abdominal pain	Yes ____	No ____	________
Nausea or Vomiting	Yes ____	No ____	________
Heartburn	Yes ____	No ____	________
Indigestion	Yes ____	No ____	________
Trouble Swallowing	Yes ____	No ____	________
Jaundice or liver trouble	Yes ____	No ____	________
Hemorrhoids or fissures	Yes ____	No ____	________
Hernia	Yes ____	No ____	________

Genitourinary

Venereal disease	Yes ____	No ____	________
Frequent urination	Yes ____	No ____	________
Burning urination	Yes ____	No ____	________

Musculoskeletal

Arthritis	Yes ____	No ____	________
Joint Swelling	Yes ____	No ____	________
Chronic Muscle Pain	Yes ____	No ____	________

Franklin Gastroenterology, PLLC

Integumentary (Skin and Breasts)

Itching problems Yes _____ No _____ ____________________
Rashes Yes _____ No _____ ____________________
Breast discharge Yes _____ No _____ ____________________
Painful breasts Yes _____ No _____ ____________________
Lumps in breasts Yes _____ No _____ ____________________

Neurological

Seizures Yes _____ No _____ ____________________
Black out spells Yes _____ No _____ ____________________
Temporary loss of vision Yes _____ No _____ ____________________
Chronic headaches Yes _____ No _____ ____________________

Psychiatric

Depression Yes _____ No _____ ____________________
Anxiety Yes _____ No _____ ____________________
Trouble Sleeping Yes _____ No _____ ____________________

Endocrine

Diabetes Yes _____ No _____ ____________________
Thyroid Problems Yes _____ No _____ ____________________

Hematological/Lymphatic

Anemia Yes _____ No _____ ____________________
Other blood problems Yes _____ No _____ ____________________
Other bleeding issues Yes _____ No _____ ____________________
Swollen glands Yes _____ No _____ ____________________

Allergies

Allergies Yes _____ No _____ ____________________
Sinus problems Yes _____ No _____ ____________________
Food allergies Yes _____ No _____ ____________________
Contact allergies Yes _____ No _____ ____________________

Women only

Irregular Menstrual Cycles Yes _____ No _____ ____________________
Painful Menstrual Cycles Yes _____ No _____ ____________________
Painful Intercourse Yes _____ No _____ ____________________
Age at Menopause Yes _____ No _____ ____________________
Birth Control Yes _____ No _____ ____________________
Could be pregnant Yes _____ No _____ ____________________

Any other concerns: ____

Physicians Signature ____________________ Date ____________