GASTROINTESTINAL MEDICINE ASSOCIATES, INC.
www.GIMEDRI.com

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OPEN ACCESS PAPERWORK

Please complete the enclosed paperwork and return to our office as soon as completed.

We require a copy of your health insurance card (front and back), insurance referral (if your insurance plan requires one), and driver's license to be enclosed with the paperwork.

Once the required paperwork is returned to our office and we receive the required information from your primary care physician, we will call you to schedule the procedure. Also at that time, we will mail to you the preparation instructions and forms necessary for the facility where you will be having your procedure.

Some forms are double sided.
Any missing information will delay the process.

Alternatively, you may complete the forms electronically on our website www.GIMEDRI.com, by clicking on the "Screening Colonoscopy Form" button on our home page.

If you have any questions regarding this, please call our office at 401-943-1300 for the Cranston office or 401-789-1860 for the Narragansett office

Thank you, Gastrointestinal Medicine Associates, Inc.

V2.0

1150 Reservoir Avenue - Suite 201
Cranston, RI 02920
(401) 943-1300

360 Kingstown Road - Suite 202
Narragansett, RI 02882
(401) 789-1860

IMPORTANT!!

PATIENT PORTAL FOR GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

***Once we have obtained your email address and entered it into our system*, you will receive an email with your username and temporary password to access our Portal along with the URL below.**

This is the web address:

https://health.healow.com/gimedri

The Patient Portal provides you with secure access to your:

- Vitals
- Diagnoses
- Upcoming Appointments
- Medical Summary
- Due dates for repeat procedures such as Colonoscopies and Upper Endoscopies
- As well as communication with our staff and providers for non-urgent issues

The Patient Portal is for non-urgent communications only! If you have an emergency needing clinical care, please dial 911.

This site is for your convenience and information purposes only and is not intended to treat or diagnose conditions. You can request refills, appointments, and ask questions.

Please allow 24 hours for a response to messages left on this site.

Request for Open Access Colonoscopy V1.1

Please fill out the following information AND provide a copy of your insurance card and driver's license and mail to our office.

NAME:_____D.O.B.:_____ Age:_____

Height:_____ Weight:_____ Primary Care Physician: _____

Date of Last Office Visit: _____

Reason for colonoscopy:

_____Screening – 45 or older

_____Family history of colon cancer or precancerous polyp (If so, which relative? _____)

_____Previous colonoscopy showing polyps

Date of prior exam, physician and name of facility _____

_____Any prior history of colitis?

MEDICATIONS AND DOSAGES (Please list all prescription and over the counter medications you currently take). A separate sheet is enclosed to record these.

Do you take:

- Aspirin **Yes No**
- Over the counter pain medication **Yes No** If yes, which one: _____
- Diabetes medication **Yes No** If yes, which one:_____
- Plavix, Coumadin or other blood thinners **Yes No** If yes, which one: _____

Do you have a diagnosis of obstructive sleep apnea? **Yes No**

Have you had excessive or prolonged bleeding from previous injury or surgery? **Yes No**

Do you have any metal implants in your body (i.e., joint replacement)? **Yes No**

Do you have a pacemaker or cardiac defibrillator? **Yes No**

LIST ALL ALLERGIES:

_____

PAST MEDICAL HISTORY (List all chronic medical conditions you have been diagnosed with)

_____

_____

_____

PAST SURGERIES (Please list all prior surgeries)

_____

_____

FAMILY HISTORY

_____

_____

SOCIAL HISTORY (I.E., Smoking, Alcohol Intake, Substance Use Disorder)

_____

_____

MEDICATION YOU ARE CURRENTLY TAKING INCLUDING VITAMINS

Name:_____Date of Birth:_____Date:_____

Medication Name	Strength	Directions for Use	Prescribing Provider

Patient Signature_____
Date_____

Physician Signature_____
Date_____
THIS IS FOR GASTROINTESTINAL MEDICINE ASSOCIATES,INC. USE ONLY

THESE FORMs MUST BE RETURNED TO OUR OFFICE AS SOON AS POSSIBLE

GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

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PATIENT INFORMATION SHEET

Patient Name _____

FIRST **MIDDLE** **LAST**

Mailing Address_____

Street Address_____

City_____**State**_____**Zip**_____**Marital Status** _____

Home Phone #_____**Cell Phone #** _____ **Work Phone#** _____

Please Circle Preferred Contact Phone Number: (Home / Cell / Work **)**

Date of Birth_____**Employer** _____**Primary Language**:_____

E-mail_____

Emergency Contact _____**Relationship:**_____**Phone#**_____

Doctor/Person Referring You _____

Primary Care Physician _____

Pharmacy_____**Phone #**_____**City and State of Pharmacy** _____

MEDICAL INSURANCE COVERAGE INFORMATION

Primary Insurance Carrier_____**Insurance ID/Member#** _____
Primary Insurance Group# _____ **Subscriber Name/DOB**_____

Secondary Insurance Carrier_____**Insurance ID/Member#** _____
Secondary Insurance Group# _____**Subscriber Name/DOB**_____

Tertiary Insurance Carrier_____**Insurance ID/Member#** _____
Tertiary Insurance Group#_____**Subscriber Name/DOB**_____

*****FOR MEDICARE PATIENTS ONLY*****
IN THE EVENT OUR OFFICE NEEDS TO GET PRIOR AUTHORIZATION FOR YOUR MEDICATIONS, DO YOU HAVE PRESCRIPTION DRUG COVERAGE?
Plan Name:_____ **ID #** _____

****PATIENTS WITH HEALTH INSURANCE****

I hereby authorize Gastrointestinal Medicine Associates, Inc., to release information to my insurance carrier(s) regarding my medical services and treatment in order to file a claim. I hereby assign all payments for medical services rendered to myself and dependents. I understand that I am financially liable for any co-pays, cost share, deductible, or co-insurance rendered to myself or dependents. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:_____**DATE:**_____

******OVER******

****PATIENTS WITHOUT HEALTH INSURANCE****

I understand that I am financially responsible for any and all services rendered to me by Gastrointestinal Medicine Associates, Inc. Payment is due at the time of service unless other arrangements have been made. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:_____DATE:_____
PLEASE CIRCLE ONE:

Race:

- American Indian or Alaska Native
- Asian
- Hispanic
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- Other Pacific Islander
- Unreported/Refused to Report
- Other Race_____

Ethnicity:

- Refused to Report
- Not Hispanic or Latin
- Hispanic or Latin

PERMISSION TO DISCUSS MEDICAL CARE

PATIENT NAME:_____ DATE:_____

PATIENT DATE OF BIRTH:_____

I,_____, will allow the physicians and staff at Gastrointestinal Medicine Associates, Inc. to discuss any and all issues concerning my medical care with

_____
_____
_____
_____
_____

RELATIONSHIP TO PATIENT: _____

NOTE: Unless Gastrointestinal Medicine Associates, Inc. is notified by you in person or by certified mail, the above PERMISSION TO DISCUSS MEDICAL CARE shall remain in effect indefinitely.

When it is necessary to contact you by telephone, i.e. to confirm or cancel an appointment, to give information to you regarding a booking or test that our office has scheduled on your behalf etc., may we call the telephone numbers which you have provided, and if you are not available may we:

_____ leave a message on your answering machine
_____ leave a message with anyone other than yourself
_____ Name of Person or Persons_____
_____ Anyone who answers

Telephone numbers we may call: _____home
_____work
_____other

Signed:_____
Date:_____ witness:_____