ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

Joseph D. Hollier, MD
Kimberly Sills, FNP-C

1587 North Bolton Avenue
Suite 1600
Alexandria, LA 71303
(318) 473-8188

PATIENT PORTAL ADDRESS: https://mycw11.eclinicalweb.com/portal351/jsp/100mp/login_otp.jsp

Our medical staff, receptionists, and nursing personnel operate as a team. We take great pride in our training, knowledge and capabilities, and we are dedicated to giving you quality care.

LOCATION

We are located at 1587 North Bolton Avenue, Suite 1600, next door to Central Louisiana Surgical Hospital. Our entrance is located on the right side of the Cenla Family Medicine building.

OFFICE HOURS

Regular office hours are 7:45 a.m. to 5:00 p.m. Monday through Thursday and 7:45 a.m. to 12:00 pm. Friday. We will try to see you at the scheduled time. We believe strongly in the value of your time and will do our best to keep you from having to wait for a long time. On occasion, emergencies can cause problems and whenever possible, you will be fully informed if there will be any delays. We would appreciate 24 hour notice if you find it necessary to cancel your appointment. During the week, each doctor is in the hospital ¾ of the time and is in the office **only** ¼ of the time.

TELEPHONE CALLS

Our telephones are answered from 7:45 a.m. to 5:00 p.m. Monday through Thursday and 7:45 a.m. to 12:00 pm. Friday. Our employees have been instructed to handle all incoming calls. This allows the doctors to attend to their scheduled patients with a minimum of interruptions during office hours.

PRESCRIPTIONS AND REFILLS

Just as we cannot treat illnesses over the telephone, we cannot prescribe medications over the telephone. Medication refills will only be handled during regular office hours and **only** if you are currently under our care. If you need a prescription refill, have the name and/or number of the medication, the pharmacy telephone number, and the dosage schedule handy when you call. Please call before 2:00 p.m. for your refills. Any calls after this time will be handled the following day. Because of our office schedule, calls to the pharmacies for refills are made in the late afternoon.

PAYMENT POLICY / INSURANCE

We have developed the following payment policy in order to avoid misunderstanding and confusion, and to specify responsibilities – both yours and ours – regarding payment for medical services.

- Payment is required for services at the time they are rendered. For insured patients covered by plans in which we are participants, we will collect applicable co pays and deductibles at the time of service. We accept payment in the form of personal check, cash, money order, Visa, MasterCard or Discover. We do not accept American Express. There will be a $25 fee charged for any NSF checks returned to this office.
- From time to time, we will ask you to present your insurance card for verification. We respectfully request that you inform us of any changes in your insurance coverage prior to seeing the physician. We request this cooperation in order to facilitate processing your medical claims accurately and timely to **your** insurance company for **your** medical benefits.
- In the event that your medical claims are denied for any reason, other than physician office error, payment will become the responsibility of the patient or responsible guarantor.
- Self payment: A 30% discount is given if the amount due is paid in full.
- Medicaid benefits will only be filed when Medicare Insurance is primary.

PATIENT CARE

AGA is a specialty clinic specializing in gastroenterology and hepatology. All of our patients are received through a physician referral. Our patients are either referred for routine colon cancer screening or gastroenterology/hepatology disorders. We will do the appropriate studies such as endoscopy and tests. **The patient, then will be referred back to the primary physician with our results and plan of care.** For the patient with liver disease, inflammatory bowel disease, or Barrett's esophagus, we will continue to follow these patients in our established patient clinics.

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

How do you plan to pay for this visit? Cash/Check_____ Visa/Mastercard_____ Insurance _____

Do you have a Medical Power of Attorney? ❑ Yes ❑ No Do you have a Living Will? ❑ Yes ❑ No

*****PLEASE PRINT*****

PATIENT_____ DATE OF BIRTH_____ AGE_____

ADDRESS_____ CITY/STATE_____ ZIP _____

SOCIAL SECURITY #_____ MARITAL STATUS: S / M / D / W GENDER: Male / Female

HOME #_____ WORK #_____ CELL # _____

YOUR EMAIL ADDRESS FOR **PATIENT PORTAL ACCESS** _____

RACE (circle one): African American Hispanic Caucasian Other: _____ REFUSED TO REPORT

ETHNICITY (circle one): Non-Hispanic Hispanic Other:_____ REFUSED TO REPORT

LANGUAGE: English Spanish Sign Language Other:_____

EMPLOYED BY_____ OCCUPATION _____

SPOUSE_____ EMPLOYED BY_____ WK # _____

RESPONSIBLE PARTY (if different from above) _____

ADDRESS _____

EMPLOYED BY_____ PHONE # _____

EMERGENCY CONTACT (other than spouse or parent) _____

REFERRED BY _____ PHARMACY YOU USE_____

INSURANCE INFORMATION

1. PRIMARY INSURANCE CO._____ PHONE # _____

ADDRESS _____

POLICY OR I.D.#_____ GROUP # _____

SUBSCRIBER_____ SUBSCRIBER DOB_____

2. SECONDARY INSURANCE CO._____ PHONE #_____

ADDRESS _____

POLICY OR I.D. #_____ GROUP# _____

SUBSCRIBER _____ SUBSCRIBER DOB _____

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

REQUIRED SIGNATURES

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION (ALL INSURANCES):

I request that payment of authorized insurance benefits be made on my behalf to Alexandria Gastroenterology Associates for any services furnished. I authorize any holder of medical information about me to be released to the insurance carrier and its agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary insurance carrier benefits be made on my behalf to Alexandria Gastroenterology Associates I authorize any holder of medical information about me be released to the Medigap/Secondary insurance carrier and it's agents to determine benefits payable for related services. I understand that I do not need to provide my Medigap/Secondary insurance carrier with information concerning Medicare claims because my signing of this authorization will allow Medicare payment information to cross-over automatically.

Signature:_____ **Date**_____

ALL PATIENTS (REQUIRED):

I understand that as a courtesy Alexandria Gastroenterology Associates will bill my insurance carrier for services rendered. I understand that I am financially responsible and agree to all charges for myself and for the members of my family, as applicable, promptly upon presentation thereof.
Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon. In the event legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney's fees and other such costs as determined by the court.

Signature:_____ **Date**_____

CONSENT TO OBTAIN EXTERNAL Rx HISTORY:

I _____ whose signature appears below, authorize Alexandria Gastroenterology Associates and its affiliated providers to view my external prescription history via the RxHub services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Signature:_____ **Date**_____

Name_____ **Date** _____

Complaint: (Symptom, Onset, Progression)

_____

Please enter the approximate year of any of the illnesses you may have had and the treating physician or medical facility.

Illness	Year	Dr/Hosp	Illness	Year	Dr/Hosp
Peptic ulcers	____	____	Thyroid Problem	____	____
Diverticulosis	____	____	Endocrine Disorder	____	____
Crohn's/Colitis/Ulcerative Colitis	____	____	Cancer & Type	____	____
Pancreatitis	____	____	Anemia	____	____
Hepatitis/Liver Ds.	____	____	Bleeding Tendency	____	____
Hemorrhoids	____	____	Kidney Disease	____	____
High Blood Pressure	____	____	Kidney Stone	____	____
Heart Attack	____	____	Prostate Trouble	____	____
Heart Murmur	____	____	Stroke	____	____
Other Heart Condition	____	____	Arthritis/Gout	____	____
Poor Circulation	____	____	Venereal Disease/Herpes/AIDS	____	____
Bronchitis/Asthma	____	____	Diabetes	____	____
Pneumonia	____	____	Other	____	____
Tuberculosis	____	____			

Please list approximate year of any surgery you may have had.

Appendectomy_____ Colectomy _____ Hysterectomy (part./comp)_____

Gallbladder _____ Stomach Surgery _____ Other Surgeries _____

Please list all medications you are now taking, including birth control pills and those you buy without a doctor's prescription (i.e. aspirin, cold tablets, etc). List name, dosage, times per day.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Please list any medication allergies.

1._____ 3._____ 5._____

2._____ 4._____ 6._____

_____ Initials

Please give the following family history:

Relative:	Age if living	Age at death	Liver Disease	Peptic Disease	Gallbladder	Irritable Bowel	Hypertension	Heart Disease	Stroke	Diabetes	Cancer & Type	Blood Disease	Lung Disease	Tuberculosis	Kidney Disease	Mental Problems	Colon Polyps	Liver Disease, Cirrhosis	Cause of Death/Comment
Father																			
Mother																			
Brother																			
Brother																			
Sister																			
Sister																			
Spouse																			
Child																			
Child																			

Please give a brief description of your job and daily activities (if retired, please state former occupation):

_____

_____

Have you had a recent tick, flea, mite, or any other pest or animal bite or scratch? If so, please describe:

_____

Have you traveled out of the country in the past two years? If so, please indicate where:

_____

What are your hobbies? _____

Do you exercise? _____

How much coffee or tea do you usually drink? _____ cups per day.

Have you ever used "street drugs"? _____ If so, please describe below:

_____

ROS (each question below needs to be answered):

Circle Y=Yes / N=No	Symptom	
Y / N	**Chest Pain**	While exercising, do you have chest pain?
Y / N	**Palpitations**	Do you feel your heart racing too fast?
Y / N	**Irregular Heart Beat**	Does your heart beat too slow or fast?
Y / N	**Edema**	Do you have swelling in your ankles?
Y / N	**Shortness of Breath**	Are you short of breath when you walk?
Y / N	**Cough**	Do you have a chronic cough?
Y / N	**Leg Cramps**	Do your legs cramp with exercise?
Y / N	**Weight Loss**	Have you lost weight recently?
Y / N	**Fever**	Are you having any fever?
Y / N	**Night Sweats/Chills**	Are you having night sweats or chills?
Y / N	**Fatigue**	Do you feel tired or weak?
Y / N	**Headaches**	Do you have frequent headaches?
Y / N	**Anemia**	Have you ever been anemic?
Y / N	**Bleeding Problems**	Do you have any bleeding problems after surgery or with cuts?
Y / N	**Numbness**	Does any part of your body get numb?
Y / N	**Seizures**	Have you ever had seizures?
Y / N	**Memory Loss**	Do you have any unusual memory loss?
Y / N	**Depression**	Do you feel depressed or sad?
Y / N	**Difficulty Swallowing**	Do you have problems swallowing solids and/or liquids?
Y / N	**Rectal Bleeding**	Are you experiencing any rectal bleeding? If so, is it bright red, maroon, or black?
Y / N	**Abdominal Pain**	Are you experiencing any abdominal pain? Upper, Lower, or Diffuse?
Y / N	**Nausea/Vomiting**	Are you experiencing any nausea and/or vomiting?
Y / N	**Change in Bowel Habits**	Are you experiencing any diarrhea, constipation, or changes in bowel pattern?
Y / N	**Colonoscopy**	Have you ever had a colonoscopy?
Y / N	**Liver Disease**	Do you have any problems with liver disease? Have you ever had Hepatitis A, B, or C?

_____ Initials

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TOBACCO CONTROL

NAME_____ **DATE** _____

ARE YOU A:

- ❑ CURRENT SMOKER
- ❑ CURRENT EVERYDAY SMOKER
- ❑ UNKNOWN IF EVER SMOKED
- ❑ FORMER SMOKER
- ❑ CURRENT SOMEDAY SMOKER
- ❑ LIGHT TOBACCO SMOKER
- ❑ NEVER SMOKER
- ❑ SMOKER, CURRENT STATUS UNKNOWN
- ❑ HEAVY TOBACCO SMOKER

CURRENT

IF 'CURRENT SMOKER': HOW OFTEN DO YOU SMOKE CIGARETTES?

- ❑ EVERY DAY
- ❑ SOME DAYS, BUT NOT EVERY DAY

IF 'CURRENT SMOKER': HOW MANY CIGARETTES A DAY DO YOU SMOKE?

- ❑ 5 OR LESS
- ❑ 6-10
- ❑ 11-20
- ❑ 21-30
- ❑ 31 OR MORE

IF 'CURRENT SMOKER': HOW SOON AFTER YOU WAKE UP DO YOU SMOKE YOUR FIRST CIGARETTE?

- ❑ WITHIN 5 MIN.
- ❑ 6-30 MIN.
- ❑ 31-60 MIN.
- ❑ AFTER 60 MIN.

IF 'CURRENT SMOKER': ARE YOU INTERESTED IN QUITTING?

- ❑ READY TO QUIT
- ❑ THINKING ABOUT QUITTING
- ❑ NOT READY TO QUIT

FORMER

IF 'FORMER SMOKER': HOW LONG HAS IT BEEN SINCE YOU LAST SMOKED?

- ❑ 1-3 MONTHS
- ❑ 6-12 MONTHS
- ❑ > 10 YEARS
- ❑ < 1 MONTH
- ❑ 1-5 YEARS
- ❑ 3-6 MONTHS
- ❑ 5-10 YEARS

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ALCOHOL MISUSE/ABUSE (AUDIT C)

NAME_____ **GENDER:**_____ **DATE** _____

DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

- ❑ YES
- ❑ NO

IF 'YES': HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

- ❑ NEVER (0 POINTS)
- ❑ MONTHLY OR LESS (1 POINT)
- ❑ TWO TO FOUR TIMES A MONTH (2 POINTS)
- ❑ TWO TO THREE TIMES PER WEEK (3 POINTS)
- ❑ FOUR OR MORE TIMES A WEEK (4 POINTS)

IF 'YES': HOW MANY DRINKS DID YOU HAVE ON A TYPICAL DAY WHEN YOU WERE DRINKING IN THE PAST YEAR?

- ❑ 1 OR 2 (0 POINTS)
- ❑ 3 OR 4 (1 POINT)
- ❑ 5 OR 6 (2 POINTS)
- ❑ 7 TO 9 (3 POINTS)
- ❑ 10 OR MORE (4 POINTS)

IF 'YES': HOW OFTEN DID YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION IN THE PAST YEAR?

- ❑ NEVER (0 POINTS)
- ❑ LESS THAN MONTHLY (1 POINT)
- ❑ MONTHLY (2 POINTS)
- ❑ WEEKLY (3 POINTS)
- ❑ DAILY OR ALMOST DAILY (4 POINTS)

INTERPRETATION

- ❑ POSITIVE
- ❑ NEGATIVE

INTERPRETATION

THE AUDIT-C IS SCORED ON A SCALE OF 0-12 (SCORES OF 0 REFLECT NO ALCOHOL USE).

- IN MEN, A SCORE OF 4 OR MORE IS CONSIDERED POSITIVE.
- IN WOMEN, A SCORE OF 3 OR MORE IS CONSIDERED POSITIVE.