Mid-State Gastroenterology

Sunil Sarvaria M.D., Lisa Trail, ANP-BC, and Dannilyn Kraft, ANP-BC
1115 Dow Street, Suite B Murfreesboro, TN 37130 615.896.6996 phone 615.896.6985 fax

WELCOME TO OUR PRACTICE

Hours: 8:00 a.m. to 5:00 p.m. Monday thru Friday- Except Holidays

All patients are required to present a photo ID at time of check-in as well as their insurance cards.
Payment for co-pays, deductibles, balance due, etc., are required at the time of service.

APPOINTMENTS: Patients are seen by APPOINTMENTS only. We will do our best to see you within twenty minutes of your scheduled appointment time. However, emergencies do arise for physicians, and our clinical staff will do their best to let you know if your appointment will be delayed. Please note: If you are thirty (30) minutes late for your appointment, AND you have not called us to let us know you will be a little late, then your appointment will be rescheduled. We have a structured appointment time and when you are late, we cannot work you in. We require a 48 hour notification of cancellation of ALL procedures scheduled at the Endoscopy Center or the Hospital. Failure to follow appointment cancellation guidelines regarding our office or scheduled procedures will result in discharge from our Practice after three No Show appointments or three cancellations as this is considered failure to follow your recommended medical treatment plan.

PHONE CALLS: Voice mail messages or messages left with our receptionists are returned as promptly as possible, usually within 24-48 hours. Please try to leave messages early in the day whenever possible. When calling, please give your full name, date of birth and the phone number where you can be reached. We do see clinic during the day. Messages are usually returned at the end of the day or the following morning.

TEST RESULTS: The nature and complexity of your test results will determine how they will be reported to you. Your results will not be given to you until the Provider has reviewed them. Possibilities include: office visit, mail, e-mail, patient portal, text or telephone call.

MEDICATION REFILLS: Refills may require up to 2-5 business day for processing, so please plan ahead and request your refills well before you are going to run out of your medication. It is the responsibility of each patient to ask for refills and update their medication list at each office visit. Refills on maintenance medications can be obtained by contacting your pharmacy. We are now submitting most prescriptions electronically: this includes some mail order companies. Prior authorization for medications requires us to review your chart and to submit a prior authorization to your insurance company for approval- please be advised this can take several days to get a response and our clinical staff have no control of the outcome of your insurance company's decision.

Our Physicians and staff at Mid-State Gastroenterology are committed to providing you with quality healthcare. If you have any further questions, please do not hesitate to ask one of our staff members. Thank you for choosing us for your medical care.

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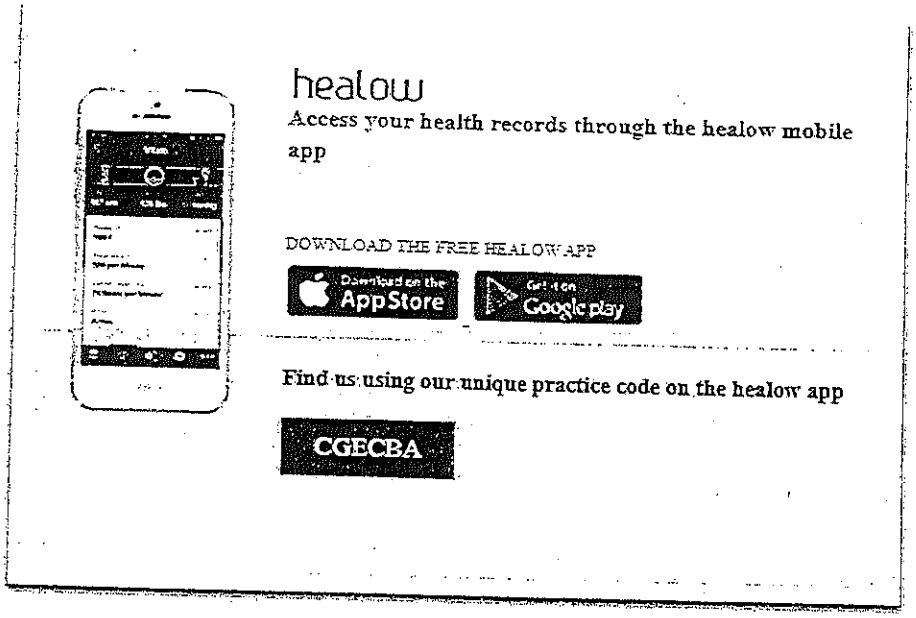
1115 B Dow Street

Murfreesboro, Tn. 37130

(615-896-6996)



Book online appointments by downloading the healow app FREE from the App Store and Google Play on your smart phones.

By entering **CGECBA**, you can find the provider of the practice on www.healow.com and the healow app. Use your patient portal credentials to log in and access your health record.

Using healow app you can:

- Send/ receive messages to your provider
- Book your next appointment
- Request refills
- Link accounts
- Connect to trackers such as Fitbit or any other device

If you have any questions on how to download the app or how to use it, ask one of our front office staff members and they can help you!

PLEASE PRINT CLEARLY

Mid-State Gastroenterology,PLLC (dba-Advanced Health Network)
1115 B Dow Street
Murfreesboro, Tn. 37130

Patient Name	SSN	Date of Birth	Age	Gender ☐ Female ☐ Male
Mailing/Street Address		City, State, Zip Code		
Marital Status ☐ Divorced ☐Married ☐ Single ☐Separated ☐Widowed		Primary Care Physician		Referring Physician
Home Phone Number ( )	Day Phone Number (work) ( )	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 ( )
Pharmacy Name:	Pharmacy Address:		Pharmacy Phone #:	

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

I hereby authorize Mid-State Gastroenterology(dba Advanced Health Network) to furnish any information or to obtain any information from any insurance carrier, physician, attorney, employer, hospital, other health care provider, or any affiliated entity concerning my medical history, illness and treatments. I hereby assign Mid-State Gastroenterology,(dba Advanced Health Network) 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 _____

Insured's Name and Relationship	Insured Date of Birth	SSN

YOUR HEALTH IS IN YOUR HANDS WITH HEALOW PATIENT PORTAL

Access Office Notes and Medical Records Securely and Quickly

Send Refill Requests to your Providers

Message your Provider

Change and cancel appointments

App. Is available for Appel and Android Users

Free and secure, access puts your medical history, lab results, tests results and medication in the palm of your hand!!!

Sign Up Today!!!!!!!!!!

EMAIL ADDRESS:_____

evised:4.7.2021

Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize (Practice Name) To Release My Medical And Billing Information To:

RELATIONSHIP			NAME OF DESIGNATED PERSON AND Phone Number
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.

(PRACTICE NAME) 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 _____

I UNDERSTAND THAT (PRACTICE NAME) WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

AdvancedHEALTH

Name: _____ DOB: _____

ALLERGIES:

MEDICATION LIST:

(Please include ***ALL*** over the counter, herbal supplements, and vitamins, that you take regularly.)

NAME OF MEDICATION	DOSAGE AMOUNT (*i.e. mg, mcg, unit*)	FREQUENCY *(i.e. once a day, at night, as needed)*	LAST TIME TAKEN

ADVANCED DIAGNOSTIC IMAGING | Advanced Health | Premier Radiology | Saint Thomas Health | PHY DATA

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: _____

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: _____

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

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Authorization for Release of Confidential Health Information

Patient name:_____ SS#_____ DOB:_____

Address:_____ City:_____ State:_____

Phone# (____)_____-_____

I, the above patient, authorize: ____ To Furnish to: _____To Receive From:

Mid-State Gastroenterology, PLLC (DBA Advanced Health)
1115 B Dow Street
Murfreesboro, TN. 37130
Phone: (615) 896-6996
Fax : (615) 896-6985

_____
Name of Healthcare Facility, Physician, Agency, Etc.

_____
Address

_____
City/ State / Zip

(____)____-_____ (____)____-_____
Phone Fax

The Following Information:
Check One _____Complete Chart
_____All G.I. Related Records
_____Other:_____

For the Following Time Period: From: _____To:_____

This disclosure is made for:_____
(Personal Records, Further Care, Transfer of Care, Insurance Legal Counsel, Disability)

- I understand that my medical records may include information relating to sexually transmitted disease, Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about a behavioral or mental health service, developmental disabilities or treatment for alcohol and/or drug abuse.
- I understand that information disclosed pursuant to this Authorization might be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying the privacy officer of MSG in writing. Notwithstanding the foregoing, I Understand that I may not revoke this authorization to the extent that MSG has taken action in reliance upon it.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my ability to receive treatment.
- I understand that this authorization shall expire, without my revocation, on the year following the date of signature unless otherwise indicated.

_____
Signature of Patient or Patient Representative Date

_____
Signature of Witness Date

For Office Use Only: _____Faxed _____Mailed Date:_____By:_____