COVID-19 CORONAVIRUS

PRACTICE UPDATE

We hope this email update finds you and yours well. We have adjusted our operating procedures to ensure the health and safety of our patients, our team, and our families. Please continue reading for important updates.

Curbside Appointments

We will be utilizing social distancing protocols. Upon your arrival, proceed to the glass front doors a team member will then approach you to check your temperature with an infrared forehead and/or ear thermometer, gather some additional health information and provide hand sanitizer. While using this approach for your appointments minimizes patient exposure to other patients, we ask that you limit family members/guests to your appointment. Apart from elderly patients needing assistance from a caretaker and younger patients who need supervision should come with you to this appointment. All Patients are to wear a MASK, otherwise the appointment should be rescheduled.

New Patient and Established Patient Intake Forms

Administrative forms can be completed upon your arrival. We ask patients bring insurance cards, picture id and a written list of all medications that you take with you as well.

Scheduled Appointments for the Remainder of 2021

With the implementation of additional safety measures, we have adjusted our scheduling procedures as well for the remainder of 2021 or whenever this crisis is over. Unfortunately, we are unable to treat as many patients in a single day as we have in the past. We have had to adjust ALL scheduled appointments for the remainder of 2021. Please be on the lookout for a follow-up email and/or text, notifying patients of your updated appointment date and time. If your new appointment conflicts with your schedule, please call our office at 803-788-1100 option 1 to reschedule.

We ask patients to please respond to their appointment confirmation request within 48 hours of the scheduled appointment. If your appointment has not been confirmed, it may be canceled and given to another patient who is on the waiting list. With high demand and limited availability of appointments during this time, if a patient does not show for their appointment, they will be required to pay a $50 deposit to reschedule.

Thank you for being our patient during and after these tough times. We will not only get through this, but we will emerge stronger after it!

PATIENT INFORMATION

Date: ________________ **Primary Care Doctor:** _____________________ **Referring Doctor:** ________________________

Patient Name: ____________________________ **Date of Birth:** ____________ **SSN** ________________________________

Address: ____

City: _____________________________________ **State:** __________________ **Zip Code:** ___________________________

Home Phone # (   ) _________________________   Cell Phone # (   ) _________________________________

PREFERRED METHOD OF COMMUNICATION: Please check mark: **Home** **Cell**

Email address: ___________________________________@___________.com_ or ___.net_ _____ ___.mil_

Marital Status:(please check mark): ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Single** **Sex (please check mark):** ☐ **Male** ☐ **Female**

Race: ________________________________ **Ethnicity:** _____________________ **Patient declines to specify:** ________

Your Employment Status: (please check mark) ☐ **Active** ☐ **Retired** ☐ **Disabled** ☐ **Unemployed**

Your Employer: ____**City:** ____________________________________

Work Phone No. ___________________________ **Occupation:** ____

Are you in Hospice? :(please check mark) ☐ **Yes** ☐ **No**

Authorized Emergency Contact (Not currently living with you): _________________________________ ___________________

Relationship to Patient: ______________________________________ **Phone:** _____________________________________

Primary Insurance :	**Secondary Insurance :**
Plan ___________________________________	Plan ___________________________________
ID # ____________________________________	ID # ____________________________________
Group # ________________________________	Group # ________________________________
Name of Insured _______________________	Name of Insured _______________________
D.O.B. of Insured ______________________	D.O.B. of Insured ______________________

PERSON RESPONSIBLE FOR THE BILL: **If you are responsible for the bill--TYPE "SELF" in the boxes below**

Name ___________________________________ **Date of Birth** ______________ **SSN:** ___________________________

Address if different than patient: __________________________________**Relationship with patient:** _______________

Pharmacy Name: ____________________________________

STREET: ____**City:**____________________________________

Pharmacy Phone: (   ) _________________________________

Authorization- Compound

This authorization form permits: Associates In Gastroenterology, P.A. to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name: ___________________________________ Birth Date: ________________

I, agree and offer no objection to the release of protected health information by the above named provider to the persons indicated below**: I.E. Spouse, Child, Parent, an Employer for work excuses and any other designated adult.**

PERSON/ENTITY	RELATIONSHIP	TELEPHONE NUMBER

Please check mark all three boxes below:

I understand that this agreement will expire in 3 years from date of signature.

I understand that I may object to future disclosures of information by revoking this agreement I can revoke this agreement at any time by contacting the above named provider/practice either in writing or in person.

Revocation will not apply to information that has already been disclosed.

_________________________________ _________________________________
Signature of Patient/Authorized Person Date

_________________________________ _________________________________
Relationship Reason if unable to sign

If the patient is not present or is unable to agree, object to the use and/or disclosure of protected health information because of incapacity or an emergency circumstances, the practitioner may use professional judgment to determine whether the disclosure is in the best interest of the individual and if so, disclose only protected health information that is directly relevant to the person's involvement with the individual's health care. The practitioner may also use professional judgement, experience with common practice and the best interest of the patient in also allowing the listed individuals to act on behalf of the patient to pick up filled prescription, medical supplies, x-rays, or the other forms of protected health information.

Welcome to Associates In Gastroenterology. This brochure is designed to provide you with helpful information about our policies and procedures of operations. If you have questions regarding any of the policies below please contact our Office Manager. The cost of care is expensive and a financial policy is a part of every medical practice.

Patient Responsibilities and Financial Policy

Patients are ultimately responsible for all charges for services provided by Associates In Gastroenterology and payment is due when services are rendered.

If a procedure is scheduled, a non-refundable deposit may be required. This deposit will be applied to any deductible or co-pay that needs to be met.

We have the right to deny any treatment that is determined a non-emergency by our physicians due to for any outstanding balance.

We accept payments by cash, personal check, debit card, VISA and MasterCard.

Insured Patients

As a courtesy, we will file your primary, secondary and tertiary insurance. If we participate with your insurance company, any amount due after the applicable contractual adjustment will be your responsibility.

Please provide us with the most updated and current information necessary to file the claim. If this is not obtained on the date of service rendered, you may be responsible for your bill. You are also responsible for notifying us of any changes in insurance. A copy of your card is required at each visit. If you do not have your card at the time of the visit, you will be asked to sign a waiver and may be billed for the services.

Please call your insurance company, if you need to verify that our office and physicians participate with them. Different insurance companies have different co-pays and deductibles. Please be aware of your individual policy requirements. You are required to pay your co-pay and/or deductible at the time of your visit with us.

We do participate with Medicare and will file insurance that is secondary to Medicare. It is your responsibility to pay your co-insurance and/or deductible at the time of service.

We are also a participating provider for SC Medicaid; however, you must have your current card at the time of service. Your card must have remaining visits left to be valid. Please verify with our office regarding our participation with any HMO Medicaid Plan.

It is the patient’s responsibility to provide us with the primary care physician referral form. Please check to see if your insurance requires a referral and verify that it is obtained before your visit. If a referral is required, but not obtained, full payment may be required from the patient at the time of service.

Assignment of Benefits and Release of Record

As a patient of our office, you agree to assign and authorize payment directly to Associates In Gastroenterology of all benefits for facility charges for services rendered by the facility.

If your insurance carrier has NOT paid your claim in full within 60 days, please call your insurance company to inquire about the status.

THE PRACTICE EMPLOYEES ARE NOT ABLE TO DEFINE YOUR INSURANCE COVERAGE

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NON-INSURED PATIENTS

All non-insured patients are able to have a discount for prompt payment and it is expected to be paid at the time of service. We do NOT offer payment plans.

Attendance, Cancellation and Missing Appointment Policy

Office Visits: If you cannot make a scheduled appointment, it must be cancelled at least one (1) business day in advance. Patients who fail to give one (1) business day notice will be considered a "no-show" and may be assessed a charge of $50.00.

Procedures: All cancellations for procedures MUST be received within three (3) business days. Failure to notify the office may result in a $100.00 cancellation fee.

Charges for Procedures

We strive to provide you with cost-effective, high quality care. You may receive four (4) separate bills:

1. Physician's technical component fee from Associates In Gastroenterology
2. The facility fee from Berkeley Endoscopy Center
3. If a biopsy is taken during the procedure, the Pathology/lab services will be billed separately. The pathologist is a doctor who reviews the tissue specimens or labs collected from your procedure. (If X-rays are ordered after the procedure, the radiologist will bill you separately for these services.)
4. Ether, L.L.C., for the anesthesia administered to you by the Certified Registered Nurse Anesthetist at the Endoscopy Center.

Returned check

There is a $35.44 charge in the event your check is returned for any reason. Our Financial Coordinator will notify you in writing and with a courtesy phone call.

Collections

We, AIG and Ether, L.L.C. reserve the right to send accounts with a balance over 60 days old to an outside collection agency. The agency does have the right to report the past due balance to the credit bureau. Should the account be referred to an attorney or collection agency, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. As the patient, you certify that you- the Insured or Guarantor- are financially responsible.

Office Policies

Your care will be provided by your Physician and Medical Assistant. The Medical Assistant will help coordinate your care under the direction of your physician. The Assistant will schedule follow up appointments, procedures, blood tests, and radiology services, as well as call in prescriptions and attend to your calls. Please direct all of your concerns to the Medical Assistant. The Physician personally makes his calls which can be placed any hour of the day. It is very difficult for a physician to make or take calls during a high volume clinic day.

Without your complete and current medical information, you are at risk of a misdiagnosis. It is in your best interest to provide us with your complete medical information. You do not have to waste time filling out forms in the waiting room! All the doctors you see are required to provide one copy of your record at no charge to you.

Our office hours are: Monday thru Thursday from 8:00 am to 5:00 pm.
Phone hours are: 8:30 am to 4:45 pm.

We are closed on the following holidays:

Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and the next day, Christmas Eve at 12pm, Christmas Day, New Year Eve at 12pm and New Year's Day**.**

Patient Portal

We now have electronic health medical record software that offers time saving efforts for you. You will be asked to provide us with an email address so you may start utilizing the portal on your **personal computer** or downloading an App called **Healow** from your **Smartphone**. This portal will enable you to make and cancel appointments, update your medications, request medication refills, access your medical records, and ask the staff and physicians questions. Get started now!!!!

Prescriptions---- Bring your medication list with you at every appointment!

We only send prescription refills electronically; you can request a refill by using the Patient Portal, provided your account is in good standing. Please allow 48 hours to process your request. Certain prescriptions may require additional authorization from your insurance company and this may take an additional business days. If you choose not to use the Patient Portal and leave a message, it is your responsibility to provide your Date of Birth and name of medication. We only use the pharmacy that you provided to us upon your initial check in and it remains on file. Please be aware that NOT all requests will be approved; it is the discretion of the physician. The physician may need to see you for an appointment if it has been awhile since your last visit with us.

Test Results

Our physicians are very concerned with giving results over the phone for a number of reasons; mainly, because it is not the most secure way to communicate. When patient and physician are face to face the communication is more effective and provides the opportunity to see reports, pictures and films. With that being said, the overall care has greatly improved. Please understand your care is our priority even though this policy may seem frustrating for you and your loved ones.

Medical Records

You are entitled to get copies of your medical records. As per South Carolina Law, Section 44-115-80 you will be charged as follows. There is a $15 processing fee plus $0.65 per page for copies up to 30 pages and $0.50 per page more than 30 pages. There will be no charge for medical records that are sent directly to your provider. Medical records will be released only after a signed Medical Release Form is directly sent to us from your Primary Care Physician. Your request will be processed within 5 business days after payment is received.

Disability & Family Medical Leave Act

For your benefit we complete medical forms such as Disability, Leave of Absence, FMLA, etc. There is a $25.00 processing fee that will need to be submitted with the form. Your request will be processed within 5 business days after payment is received.

I have acknowledged and read the above policies regarding my financial and Patient Responsibilities.

Patient Name: (Print) ____ Date: ______________

Patient/ Responsible Party and/or Legal Guardian Signature: ____

Acknowledgement of Receipt of
Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

____

Signature: Patient's Name / Personal Representative (as defined by HIPAA)   Date

____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other ____
  ____

PATIENT HISTORY

Providing the following information is very important to your health. Take your time. Complete the information in full and correctly.

WEIGHT:	PULSE:	EKG:	Colonoscopy:
HEIGHT:	O2:	RECENT BLOOD WORK:	Endoscopy:
BP:	Pharmacy:		

THE ABOVE INFORMATION WILL BE OBTAINED BY THE TRIAGE MEDICAL ASSISTANT:

MEDICATIONS:

Please check mark if you DO NOT take medications ☐

No.	Name of Medications	Dose	How often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

ALLERGIES (Please check mark here if you have NO Allergies): ☐ **Egg Allergy:** Yes ☐ No ☐

No.	Name	Reaction
1		
2		
3		
4		

MEDICAL HISTORY:

No.		Name	Phone Number	Fax Number
1	Primary Care Physician			
2	Cardiologist			
3	Pulmonologist			

Yes No
☐ ☐ Anemia
☐ ☐ Anxiety
☐ ☐ Aortic Aneurysm

☐ ☐ Asthma
☐ ☐ Use an Inhaler?
☐ ☐ Use Nebulizer?
☐ ☐ Take Prednisone
☐ ☐ On home Oxygen

☐ ☐ Arrhythmia
☐ ☐ Have a Pacemaker?
☐ ☐ Do you have Defibrillator?
☐ ☐ On Blood Thinners?

☐ ☐ Arthritis
☐ ☐ Bipolar Disorder
☐ ☐ Bleeding problem
☐ ☐ Blood transfusion

☐ ☐ Cancer? ________________
☐ ☐ Cholesterol

Yes No
☐ ☐ Cataracts
☐ ☐ Surgery?
☐ ☐ Right eye?
☐ ☐ Left eye?
☐ ☐ Both eyes?

☐ ☐ COPD?
☐ ☐ On Home Oxygen?
☐ ☐ Nebulizer?
☐ ☐ Take Prednisone

☐ ☐ Coronary Heart Disease
☐ ☐ Stent? When? ___________
☐ ☐ On Blood Thinners?

☐ ☐ Depression

☐ ☐ Diabetes
☐ ☐ Do you take Insulin?

☐ ☐ Endometriosis

☐ ☐ Glaucoma
☐ ☐ Right eye?
☐ ☐ Left eye?
☐ ☐ Both eyes?

Yes No
☐ ☐ Heart valve replacement?
☐ ☐ Mechanical or PIG Valve?
When:______________________
☐ ☐ On Blood Thinners?

☐ ☐ Hypertension

☐ ☐ Hepatitis A
☐ ☐ Hepatitis B
☐ ☐ Hepatitis C
☐ ☐ HIV

☐ ☐ Joint replacements

☐ ☐ Leg Clots (DVT)
When? _______________
☐ ☐ On Blood Thinners?

☐ ☐ Parkinson's Disease
☐ ☐ Pulmonary Embolism
☐ ☐ Pulmonary Hypertension

☐ ☐ Renal Failure
☐ ☐ On Dialysis?

☐ ☐ Seizures
☐ ☐ Sickle Cell Anemia
☐ ☐ Sleep Apnea
☐ ☐ CPAP?

IMMUNIZATIONS: Please check mark each vaccine that you have received:

Flu Shot: ☐	PPD/TB: ☐	Covid19: ☐	Hepatitis A: ☐	Hepatitis B: ☐

PREVIOUS HOSPITALIZATIONS, EMERGENCY ROOM VISIT OR SURGICAL HISTORY: ☐ **NONE**

No.	(Month/Year)	REASON	WHERE
1			
2			
3			
4			
5			

FAMILY HISTORY: Has any of your immediate family (parents, siblings, uncle, aunts, children, and grandparents had any of the following?

(Please check marked YES or NO for each listing below

				if yes, age of diagnosis?	What relative?
1	Colon or rectal cancer	YES ☐	NO ☐		
2	Gastric cancer	YES ☐	NO ☐		
3	Colon polyps	YES ☐	NO ☐		
4	Crohn's Disease	YES ☐	NO ☐		
5	Ulcerative Colitis	YES ☐	NO ☐		
6	Liver Disease	YES ☐	NO ☐		

SOCIAL HISTORY: Please use a check mark for to the following questions:

No.	Agent	Information
1	Tobacco: No ☐	Yes: 1. How often do you smoke cigarettes? Every day ☐ or some days ☐
		2. How many cigarettes a day do you smoke?
		3. How soon after you wake up do you smoke your first cigarette?
		4. Are you interested in quitting? ☐ YES ☐ NO
2	Alcohol: No ☐	Yes: 1. How often did you have a drink containing alcohol in the past year?
		a. Daily ☐ b. Weekly ☐ c. Monthly ☐
		2. How many drinks did you have on a typical day when you were drinking in the past year?
		a. 1 drink ☐ b. 3 drinks ☐ c. 5 drinks ☐ d. 7 drinks ☐ e. 9 drinks ☐
		3. How often did you have 6 or more drinks on one or more occasions in the past year?
		a. Never ☐ b. Daily ☐ c. Weekly ☐ d. Monthly ☐
3	Drugs: No ☐	Yes: 1. What type of drugs?
		a. Marijuana ☐ d. Heroine ☐
		b. Crack ☐ e. Methamphetamine ☐
		c. Cocaine ☐

REVIEW OF SYSTEM: ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS MORE THAN 6 TIMES A YEAR?

Please use a check mark to each that apply: Please check mark here if NO Symptoms: ☐

General / Constitutional:	Confusion ☐
	Fatigue ☐
	Fever ☐
	Weight loss ☐
Ophthalmologic	Cataracts ☐
	Blurred Vision ☐
	Discharge ☐
	Itching and redness ☐
Ear / Nose / Throat	Hoarseness ☐
	Decreased hearing ☐
	Dry mouth ☐
	Sinus trouble ☐
Respiratory	Cough ☐
	Shortness of breath at rest ☐
	Wheezing ☐
Cardiovascular	Chest pain at rest ☐
	Dizziness ☐
	Irregular heartbeat ☐
	Palpitations ☐
Gastrointestinal	Exposure to HIV ☐
	Gas ☐
	Abdominal pain ☐
	Exposure to Hepatitis ☐
Genitourinary	Blood in urine ☐
	Difficulty urinating ☐
	Painful urination ☐
Musculoskeletal	Knee pain ☐
	Muscle aches ☐
	Sciatica ☐
	Swollen joints ☐
Skin	Bruises easy ☐
	Hives ☐
	Itching ☐
	Rash ☐
Neurologic	Numbness ☐
	Loss of strength ☐
	Seizures ☐
Psychiatric	Anxiety ☐
	Depressed mood ☐
	Substance Abuse ☐
	Suicidal thoughts ☐

Directions to Columbia office from:

1. ***N.E. Columbia***: Go toward I-20 on Clemson Rd., take a right onto Wildewood Centre Drive at the Shell Gas Station/Dunkin Donuts.

We are the last building on the right hand side of the road:

1070 and 1072 Wildewood Centre Drive

2. ***N.W. Columbia***: Take I-20 toward Florence, get off on Exit 80 Clemson Rd. Take a left on Clemson Rd., at the first traffic light, then take a left onto Wildewood Centre Drive at the Shell Gas Station/Dunkin Donuts.

We are the last building on the right hand side of the road:

1070 and 1072 Wildewood Centre Drive.

3. ***Camden***: Take I-20 W towards Columbia, take Exit 80 to Clemson Rd., and turn right onto Clemson Rd. get into the far left hand lane at the traffic light turn left at the Shell Gas Station/Dunkin Donuts on to Wildewood Centre Drive.

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1070and 1072 Wildewood Centre Drive

4. ***Sumter***: Take 378 to 601 North. Take a left onto Screaming Eagle Rd. into Pontiac. Then take I-20 W towards Columbia, take Exit 80 to Clemson Rd. turn right onto Clemson Rd. get into the far left hand hand lane, then turn left at the Shell Gas Station/Dunkin Donuts on to Wildewood Centre Drive.

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Sumter: Take 521 to Camden, get on I-20 W towards Columbia. Take Exit 80 to Clemson Rd. Turn right onto Clemson Rd. get into the far left hand lane and turn left at the Shell Gas Station/Dunkin Donuts on to Wildewood Centre Drive.

We are the last building on the right hand side of the road at:

1070 and 1072 Wildewood Centre Drive

5. ***Lexington:*** Take I-20 E towards Florence, take Exit 80 to Clemson Rd., turn left onto Clemson Rd. at the first traffic light, and turn left at the Shell Gas Station/Dunkin Donuts on to Wildewood Centre Drive.

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