

**Ronald M Angles, DO**  
**112 Airport Business Park Drive, Suite G**  
**Shelbyville, TN 37160**  
**931-735-6036**

FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ Which do you prefer? \_\_\_\_\_ Home \_\_\_\_\_ Cell

EMAIL ADDRESS: \_\_\_\_\_

I give permission to Digestive Healthcare of Middle Tennessee to send emails to the above address- \_\_\_\_\_ Yes or \_\_\_\_\_ No

Marital Status (please circle):                      Single                      Married                      Divorced                      Widow

How did you hear about us?: \_\_\_\_\_

PRIMARY DOCTOR: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SUBSCRIBER ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME (if not the patient): \_\_\_\_\_ SSN: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SECONDARY INSURANCE CO: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SUBSCRIBER ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

PHONE #: (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

For appointment reminders do you prefer to be contacted by Phone or by Text Messaging? \_\_\_\_\_

If you want to be contacted by text messaging what company is your cell phone carrier? \_\_\_\_\_

We will contact you by phone or mail for questions, results, scheduling, and other needs unless you notify us otherwise.

**I hereby authorize permission of treatment by designee within Digestive Healthcare of Middle Tennessee. I further authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to Digestive Healthcare of Middle Tennessee, as indicated on the claim. A copy of the signature is as valid as the original. I agree that I am responsible for paying Digestive Healthcare of Middle Tennessee any balances including deductibles, co-payments, and non-covered services, (including those not covered under my group plan or those deemed by my insurance company not medically necessary) which remain after insurance payments have been made. If full payment cannot be made, I agree to make arrangements with a Digestive Healthcare of Middle Tennessee representative.**

Patient's Signature or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

### PATIENT MEDICAL HISTORY

**Please Circle Yes If Any Of These Apply To You**

Colon Polyps	Yes	Blood in Stool		Yes
Colon Cancer	Yes	Change in Bowel Habits		Yes
Diverticulosis	Yes	Difficulty Swallowing		Yes
Diverticulitis	Yes	Sleep Apnea (CPAP Y or N )		Yes
GERD/Heartburn	Yes	Peptic Ulcer Disease		Yes
Barrett's Esophagus	Yes	Heart Attack		Yes
Esophageal Stricture	Yes	Angina		Yes
Thyroid Disorder	Yes	Irregular Heart Beat		Yes
Arthritis	Yes	Glaucoma		Yes
Hypertension	Yes	Heart Murmur		Yes
COPD or emphysema	Yes	Artificial Heart Valve		Yes
Anemia	Yes	Stroke		Yes
Irritable Bowel Symptoms	Yes	Tremors		Yes
Chronic Diarrhea	Yes	Blood Clot	Lung    Leg	Yes
Constipation	Yes	Kidney Disease		Yes
Elevated Liver Function Tests	Yes	Elevated Cholesterol		Yes
Cirrhosis of the Liver	Yes	Diabetes		Yes
Fatty Liver	Yes	Fibromyalgia		Yes
Hepatitis C	Yes			
Hepatitis C Relapse	Yes			
Gilberts Syndrome	Yes			
Asthma	Yes			
Coronary Artery Disease	Yes			
Depression	Yes			
Headaches	Yes			
Weight Loss	Yes			
Ulcerative Colitis	Yes			
Crohn's Disease	Yes			
Pneumonia	Yes			
Frequent Cough	Yes			
Breast Cancer	Yes			
Lung Cancer	Yes			
Prostate Cancer	Yes			
Nausea and/or Vomiting	Yes			
Left- sided Pain    Upper    Lower	Yes			
Right-sided Pain    Upper    Lower	Yes			
Epigastric Pain	Yes			
Memory Loss	Yes			
Blood in Urine	Yes			

### SURGICAL HISTORY

\_\_\_\_\_ *I have not had any surgeries.*

**Please Circle Yes If You Have Had Any Of The Following**

Appendectomy				Yes
Gallbladder Removal				Yes
Knee Surgery	Left	Right	Both	Yes
Hip Replacement	Left	Right	Both	Yes
Thyroid Surgery				Yes
Heart Catheterization				Yes
Heart Surgery	_____			Yes
Breast Biopsy	Left	Right	Both	Yes
Prostrate Surgery				Yes
Hernia Surgery				Yes
Bowel Surgery	_____			Yes
Hysterectomy	Total	Partial		Yes

Have you ever had a colonoscopy? Yes    No

What year? \_\_\_\_\_

What was found? \_\_\_\_\_

## REVIEW OF SYMPTOMS

Please Circle The Symptoms That Apply To You

Development Problems	Yes
Eye Trauma	Yes
Eye Inflammation	Yes
Poor Growth	Yes
Ear Discharge	Yes
Total Deafness	Yes
Coughing Up Blood	Yes
Exposure to Lung Toxins	Yes
Blockage of Blood Flow to the Legs	Yes
Severe Blood Pressure Drop When Standing	Yes
Perforation (holes) in the Intestines	Yes
Hiccups Longer Than One Week	Yes
Continuous Muscle Pains	Yes
Loss of Muscle Mass	Yes
Total Absence of Hair on the Scalp	Yes
Total Body Skin Rash	Yes
Facial Paralysis	Yes
Total Lack of Taste to Foods	Yes
Hallucinations	Yes
Delusions	Yes
Marked Change in the Size of Hands or Feet	Yes
Abnormal Sexual Development	Yes

\_\_\_\_\_ **None of these symptoms apply to me**

What is your height? \_\_\_\_\_ How much do you weigh? \_\_\_\_\_

Have you lost weight? Yes No If yes, how much? \_\_\_\_\_

### SOCIAL HISTORY

Do you smoke? Yes No  
How many packs daily? \_\_\_\_\_

Do you drink alcohol? Yes No  
How much alcohol do you use in the average week? \_\_\_\_\_

Do you have any tattoos? Yes No  
If yes, what year did you get your first tattoo? \_\_\_\_\_

Have you ever had a blood transfusion? Yes No

### FAMILY HISTORY

Has anyone in your family ever had colon cancer? Yes No  
If yes, Who? \_\_\_\_\_

Has anyone in your family ever had colon polyps? Yes No  
If yes, Who? \_\_\_\_\_

Patient Name **X** \_\_\_\_\_

Date \_\_\_\_\_

# Ronald M Angles, DO

112 Airport Business Park Drive Suite G ♦ Shelbyville, TN 37160 ♦ 931-735-6036

## PATIENT CURRENT MEDICATION LISTING

(Include Prescriptions, Over the Counter, and Herbals)

MEDICATION	MG	HOW OFTEN

### Allergies and Reaction to Medication

<u>MEDICATION</u>	<u>REACTION</u>

Patient: \_\_\_\_\_ D.O.B. : \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Location: \_\_\_\_\_

Ronald M. Angles, D.O.  
Board Certified Gastroenterologist  
112 Airport Business Park Drive, Suite G Shelbyville, TN 37160  
Phone: 931/735-6036 Fax: 931/735-6293

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING, BUT NOT LIMITED TO MEDICAL RECORDS, APPOINTMENT TIMES AND TEST RESULTS.**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and AIDS Related Complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, or serious communicable diseases as defined by the Department of Public Health Rules including Hepatitis B, Venereal Disease, and Tuberculosis.

The information identified above may be used by or disclosed to the following individual(s) or organization(s):

Name	Relationship	Phone
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Name	Relationship	Phone
------	--------------	-------

Name	Relationship	Phone
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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations, although, such use/disclosure may be subject to other Tennessee and federal laws. In signing this form, I give authorization to Digestive Healthcare of Middle Tennessee and its representatives to use or disclose protected health information including, but not limited to appointment times and test results.

_____	<b>X</b> _____	_____
Signature of Witness	Signature of Patient or Legal Representative	Date

_____	_____
Printed Name /Relationship of Other Authorized Person	Date

**ACCEPTANCE OF MESSAGES**

I give the employees and representatives of Digestive Healthcare of Middle Tennessee permission to leave a message on my answering machine or voice mail when calling my home or cell phone number.

<b>X</b> _____	_____
Signature of Patient or Legal Representative	Date

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Digestive Healthcare of Middle Tennessee's Notice of Privacy Practices provides information about how we may use and disclosed Protected Health Information about you. By signing this form, you are acknowledging that you have been offered a copy of Digestive Healthcare of Middle Tennessee's Notice of Privacy Practices.

**X**\_\_\_\_\_ I have been offered a copy of the Notice of Privacy Practices, but have declined.

Initials

Signature or Patient or Guardian: **X**\_\_\_\_\_ Today's Date:\_\_\_\_\_

## Financial Policy

Thank you for choosing Dr. Ronald M. Angles as one of your healthcare providers. We are committed to your treatment being successful and pleasant. Our office staff will work very hard to make sure that your paperwork is filed accurately and promptly. Please understand that insurance reimbursement can be a long and difficult process. In fact, insurers will routinely stall, deny, and reduce payments. Our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement, while reducing the time in which payment is received.

In order to provide you with the highest quality service while keeping our billing costs low, we offer paperless billing through Easy Pay. We simply maintain your credit, debit, or check card number on file to satisfy all co-pays, deductibles, and balances not covered by your insurance. Our billing staff will be happy to give you more information and help you register for the no charge Easy Pay system.

To ensure that Dr. Angles can continue to provide quality medical services to the community, the following credit policies shall be enforced:

- **Insurance Card/Photo ID** – At the time of your initial visit, please present your insurance card and photo ID. This is for protection of your identity. At the time of future visits, please present your insurance card if there have been any changes to your insurance.
- **Verification of Insurance** – All insurance information will be subject to verification.
- **Change of Demographics** – Please notify us, when you check in, if you have had any changes in your address, phone number, insurance, or marital status. Also, please notify us at that time if you have had any changes in your medical history including but not limited to medications.
- **Payment at Time of Service** - We will collect the applicable portion of your remaining deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will collect it at that time. We accept cash, checks, Visa, MasterCard, American Express, Discover, and Easy Pay.
- **Participating Insurance Plans** – If we participate with your plan, we will bill your insurance carrier for you if you have provided us with the required insurance information and signed an assignment of benefits statement. We will incur the cost of this billing as a courtesy to you. Your co-payment will be collected at the time of service. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from your primary care physician and bring with you to your visit. We are not able to obtain back dated referral authorizations.
- **Courtesy Claims** - If we do not participate with your insurance, we will file your claims for you if you have provided us with the required insurance information and signed an assignment of benefits statement. We will incur the cost of this billing as a courtesy to you. You will be responsible for following up to make sure the insurance company has sent us payment in a timely manner. If we do not receive payment from them within 45 days, you will be billed for any unpaid balance.
- **Secondary Insurance** – When you have more than one insurance plan it does not necessarily mean that your services are covered at 100%. Secondary Insurers will pay as a function of what your primary carrier pays. We will bill your secondary insurance carrier for you if you have provided us with the required insurance information and signed an assignment of benefits statement. We will incur the cost of this billing as a courtesy to you. You are responsible for any balances after your insurance(s) has cleared.
- **Insurance Unpaid Balance** - If your insurance denies our charges, or does not pay us in a timely manner, you will be billed for any unpaid balance.
- **Medicare** – We are a participating provider with Medicare and we will bill Medicare for all your covered charges if you have Medicare as your insurance. If you have supplemental insurance, Medicare will automatically forward the claim to that carrier for payment, also. If payment is not received from the secondary insurance company within 45 days of submission date, we will bill you for the balance due. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
- **Usual and Customary Rates** – Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

- **Self-Pay Patients** – Patients without insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to services in order to make payment arrangements.
- **Divorce Decrees** – This office is not a party to any divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying parent/guardian.
- **Minor patients** – The parent or guardian accompanying a minor is responsible for full payment.
- **No show or missed appointments** – When an appointment is scheduled with the doctor time is specifically allocated for you. When an appointment is not canceled in advance and the patient “no shows”, another person that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment. Please call the office as soon as you can in order to reschedule. We ask for 24 hour notice unless there is an emergency.
- **Third Party Litigation** – The physician will not become involved in disputes arising out of third party litigation (ex: automobile accidents, liability claims, etc.) with the exception of verified Workers’ compensation claims, or claims involving Medicare and Medical Assistance.
- **Delinquent or Bad Debt Accounts** – Patients with unpaid delinquent accounts or accounts which have been written off due to bad debt may be denied treatment if not medically required.
- **Charity Allowances** – If a patient is determined to be financially indigent (after completing the forms including financial statement), the billing department will review the account for a charity allowance.
- **Discounts** – Accounts will not be reduced or discounted. We are contractually obligated with the various insurance carriers to charge the same fees across the board. We do offer a prompt pay discount for services paid in full prior to being performed. We also offer a prompt pay discount for using the Easy Pay system. Please do not ask the physician to discount your services. Our billing staff is well trained to handle any questions or concerns that you may have regarding your account.
- **Referral for Outside Collection** – Accounts which cannot be collected by our office after normal in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action in accordance with this office’s established guidelines.
- **Payment Arrangements** – If a patient is unable to make full payment of their balance when due, periodic, partial payments may be approved in accordance with our billing office policies. We encourage the use of our Easy Pay System for the convenience and security protection of our patients.
- **Refunds** – Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients’ refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than \$5.00 will not be issued unless specifically requested. The credit balance will remain on your account.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (931) 735-6036.

I have read and have a full understanding of Dr. Ronald M. Angles’ office financial policy.

Patient Signature: \_\_\_\_\_

Relationship (If patient is minor or not competent to sign): \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_