Kellen Jex, MD — Board Certified Gastroenterologist
Sarah Gousset, NP-C
136 Jeff Davis Blvd., Suite B | Natchez, MS 39120
Phone: (601) 492-2224 | Fax: (601) 492-2231
www.MissLouGI.com

PATIENT INFORMATION FORM

Please complete all sections clearly and in full. This information is confidential and protected under HIPAA.

PATIENT DEMOGRAPHIC INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

SSN _____ Preferred Language _____ Preferred Contact Method _____

Home Address (Street) _____ Apt / Unit _____ City _____

State _____ ZIP Code _____ County _____ Country _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Preferred Contact Method _____

Race / Ethnicity _____ Occupation _____ Employer _____

Referring Physician / Provider _____ Primary Care Physician (PCP) _____

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact

Last Name _____ First Name _____ Relationship to Patient _____

Primary Phone _____ Secondary Phone _____

Address (if different from patient) _____ City _____ State _____

Secondary Emergency Contact

Last Name _____ First Name _____ Relationship to Patient _____

Primary Phone _____ Secondary Phone _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company Name _____ Plan / Group Name _____

Policy / Member ID Number _____ Group Number _____ RxBIN / PCN (if applicable) _____

Policyholder's Full Name _____ Relationship to Patient _____ Policyholder DOB _____

Insurance Phone (on back of card) _____ Claims Mailing Address _____

Do you have a separate Pharmacy / Prescription Card?

Pharmacy Plan / Insurance Name _____ RxBIN Number _____ RxPCN _____

RxGRP / Group Number _____ Member ID _____ Pharmacy Phone _____

Secondary Insurance (if applicable)

Insurance Company Name _____ Plan / Group Name _____

Policy / Member ID Number _____ Group Number _____ Effective Date _____

Policyholder's Full Name _____ Relationship to Patient _____ Policyholder DOB _____

Patient / Guardian Signature _____ Printed Name _____ Date _____

By signing above, I certify that the information provided is accurate and complete to the best of my knowledge.

For office use only: Date Received: _____ *Verified by:* _____ *Chart #:* _____

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MEDICAL HISTORY FORM

Name _____ Date of Birth _____

1. MAIN COMPLAINT – THE MAIN REASON YOU ARE SEEING THE DOCTOR TODAY: PLEASE CHECK all that apply.

☐ Abnormal Liver Test	☐ Constipation	☐ Gerd-Heartburn-Indigestion	☐ Painful Swallowing
☐ Bloating	☐ Diarrhea	☐ Hepatitis	☐ Weight Loss
☐ Blood in Stool	☐ Difficulty Swallowing	☐ Abdominal Pain	☐ Elevated Liver Enzymes
☐ Change in Bowel Habits	☐ Fever	☐ Nausea	☐ Hemorrhoids
☐ Vomiting	☐ Vitamin D Deficiency	☐ Anemia	☐ Rectal Bleeding

If OTHER, please explain: _____

2. GENERAL MEDICAL HISTORY: PLEASE CHECK all that apply to your past medical history.

☐ Collagen Vascular Disease	☐ Diabetes	☐ Heart Valve Replacement/Disease
☐ Dialysis	☐ High Blood Pressure	☐ Thyroid Disorder
☐ Kidney Disease	☐ Congestive Heart Failure	☐ Heart Murmur
☐ Heart Attack	☐ Heart Disease	☐ Mitral Valve Prolapse
☐ Heart Stents	☐ Lung Disease	☐ Stroke

If OTHER, please explain: _____

3. GASTROINTESTINAL MEDICAL HISTORY:

***HAVE YOU EVER HAD A COLONOSCOPY?** ☐ **YES -** ☐ **NO**

PLEASE CHECK all that apply to your past GI medical history.

☐ Colon Polyps	☐ Ulcer Disease	☐ Liver Disease	☐ Colon Cancer
☐ Irritable Bowel Syndrome	☐ Pancreatitis	☐ GI Bleeding	☐ Inflammatory Bowel Disease
☐ Reflux (GERD)	☐ Ulcerative Colitis	☐ Hepatitis	☐ Crohn's Disease

If OTHER, please explain: _____

4. PAST SURGICAL HISTORY:

PLEASE LIST ALL OPERATIONS YOU HAVE EVER HAD:

_____ _____ _____

5. ALLERGIES:

☐ ***NO KNOWN DRUG ALLERGIES*** **LATEX** ☐ **YES** ☐ **NO**

6. FAMILY HISTORY

Relation	Current Age (if living)	Age at Death	Colon Polyps	Colon Cancer	Crohn's Disease	Ulcerative Colitis	Liver Disease
Father			☐	☐	☐	☐	☐
Mother			☐	☐	☐	☐	☐
Brother			☐	☐	☐	☐	☐
Sister			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

ADDITIONAL NOTES/DETAILS:

_____

_____

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Medical Records Release Consent Form

Please release all medical records regarding medical care for:

Patient Name _____

Date of Birth _____

Social Security Number _____

Address _____

Address (cont.) _____

Home Phone _____ Cell _____

From:

Facility / Provider Name _____

Phone Number _____ Fax Number _____

To: Miss-Lou GI

136 Jeff Davis Blvd., Suite B Natchez, MS 39120

Phone 601-492-2224 Fax 601-492-2231

I HEREBY AUTHORIZE THAT I AM THE PATIENT OR HAVE LEGAL REPRESENTATION TO RELEASE PROTECTED HEALTH INFORMATION FOR THE ABOVE MENTIONED PATIENT.

PATIENT OR LEGAL GUARDIAN SIGNATURE:

_____

Signature

DATE:

_____

Date

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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF HEALTH INFORMATION

Which methods of communication may we use to contact you?

- ☐ Home phone – leave message to return call without details
- ☐ Home phone – leave message with details
- ☐ Cell phone – leave message to return call without details
- ☐ Cell phone – leave message with details
- ☐ Letter with details
- ☐ E-mail with details

With whom do you authorize us to discuss your health information?

Name *(please print)*	**Relationship to Patient**	**Contact Number**	**Date**

THIS AUTHORIZATION MAY BE REVOKED OR REPLACED AT ANY TIME.
SIGNING THIS FORM WILL RENDER ANY PREVIOUSLY SIGNED FORM ON FILE VOID

Signature of Patient / Legal Guardian / Legal Representative _____ Date of Birth _____ Date _____

If patient is under 18 years of age the signature of a parent or guardian is required.

Name of Legal Guardian / Legal Representative (please print) _____ Relationship to Patient _____

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Patient Name _____

GMED Medication Information Consent

What is GMED?

GMED operates an electronic network which securely connects pharmacies, care providers and benefit managers by allowing for the private electronic movement of current and historical clinical health information between different health systems, including ours here at Miss-Lou GI. This information includes accurate histories of dispensed patient medications.

What is Medication Information and how is it used?

The GMED Medication History service allows healthcare professionals to access a patient's dispensed medication history across different unrelated prescribers. This service can be used while providing routine health care as well as during emergencies. In both cases, accurate patient medication information enables healthcare providers to make safe, accurately informed treatment plans with their patients.

Consent

I acknowledge that by signing this form I consent to Miss-Lou GI accessing and receiving my medication history data from the GMED network. I understand I may revoke this consent at any time by providing written notification to Miss-Lou GI.

_____ _____
Patient Signature Date

If patient is under 18 years of age the signature of a parent or guardian is required.

_____ _____
Parent or Guardian Date

MLG
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This is a Medical Information Consent required by law to ensure that you are aware the ways in which Miss-Lou GI, PLLC may use or disclose your health information for treatment.

Your Medical Health Information is Treated as Confidential. In general, any information that is about your health, the health care you receive, or payment for that care, is considered confidential and protected by Miss-Lou GI. How we use and disclose medical information is described in detail in the Miss-Lou GI Medical Information Notice, which is available for your review by asking the Health Information Department or any member of our staff.

Using and Disclosing Information for Treatment, Payment and Health Care Operations. Miss-Lou GI is permitted by law to use and disclose your medical information for treatment, payment, and health care operations. Miss-Lou GI participates in various health information exchanges where we disclose your health information, as permitted by law, to other health care providers for your treatment, or for payment or other health care operations purposes. For instance, we can share necessary information to bill your insurer. Please read the Notice for a complete description of the ways in which we use and disclose your medical information for these purposes.

Restrictions on How Miss-Lou GI Uses and Discloses Your Health Information. You can ask Miss-Lou GI to restrict the medical information used or shared about you for treatment, payment, and health care operations. We may not be able to agree with your request and will tell you so. If we do not agree to your request, we are bound to follow it.

Your Right to Revoke This Consent. You can take away this Consent at any time if you do so in writing. Please consult the Notice or the Health Information Department for more information on how to revoke this Consent. Your revocation will not apply to any use or disclosure of your medical information by Miss-Lou GI prior to the revocation and based on the original Consent.

Miss-Lou GI Right to Change Its Notice Form. We have the right to change our Notice at any time. If we do so, you may obtain a copy of the revised Notice by consulting the Health Information Department or any member of our staff.

Please sign below to indicate that you have read this Consent and agree with its terms.

Signature of Patient / Legal Guardian / Legal Representative	Date of Birth	Date

If patient is under 18 years of age the signature of a parent or guardian is required.

Name of Legal Guardian / Legal Representative (please print)	Relationship to Patient

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MEDICAL APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Miss-Lou GI. When you schedule an appointment with Miss-Lou GI, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective March 14, 2023 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$50.00 fee**.
- After **THREE** consecutive no show or cancellation/reschedule appointments without a **24 hour notice**, the patient may be **dismissed** from Miss-Lou GI.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.
- As a courtesy, Miss Lou GI utilizes an automated appointment reminder system via phone, text and email. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, Katie Watts, who may be able to waive the No Show fee.

You may contact Miss-Lou GI 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Miss-Lou GI (601) 492-2224

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Patient/Legal Guardian)

Relationship to Patient

Printed Name

Date

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OFFICE POLICIES

It is our mission to efficiently deliver high-quality, comprehensive, medical care to you, our valued patient. To achieve this goal, we request all patients adhere to the following administrative policies. Your cooperation is appreciated. Noncompliance with the practices policies may result in fees as stated below.

MEDICATION REFILLS

- **Please request your medication refills at the time of your visits. This provides patients the timeliest refill service.**
- Allow **2 business days** to process refill requests made by phone or patient portal email.
- **Please note** medications ordered elsewhere (i.e.: specialist) must be refilled by the original ordering physician unless previously approved by your provider.

INSURANCE REFERRALS

- 48 hours' notice is requested for non-urgent referrals.
- All referrals are created and transmitted electronically. Paper copies are not necessary.

TEST RESULTS

- **Results of tests ordered by other doctors (i.e., specialist) are not available through this office. Please contact ordering physician's office or facility for results.**
- Lab testing can take 2-30 days to process depending on tests ordered. You will be contacted regarding results within 48 hours of **receipt of all test results** ordered by our providers.
- Lab results ordered by our providers can be viewed and downloaded through your online patient portal. Mailed copies of test results are available directly from the lab upon your request at the time of testing. We do not mail test results.

I, (Please Print) _____ , DOB: _____ have read, understood, and agree to the above policies.

_____ _____ _____

Signature of Patient / Legal Guardian / Legal Representative | Date of Birth | Date

If patient is under 18 years of age the signature of a parent or guardian is required.

_____ _____

Name of Legal Guardian / Legal Representative (please print) | Relationship to Patient