



# Gastrointestinal Specialists, PC

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## MAIN OFFICE & SURGERY CENTER

80 Humphreys Center  
Suite 200  
Memphis, TN 38120  
Tel (901) 578-2538 or  
Tel (901) 761-3900  
Fax (901) 578-2572

Bartlett Office  
7865 Educators Lane  
Suite 300  
Bartlett, TN 38133  
Tel (901) 761-3900

Covington Office  
1995 Highway 51 South  
Suite 203  
Covington, TN 38019  
Tel (901) 476-9603

Millington Office  
7777 Church Street  
Millington, TN 38053  
Tel (901) 873-4880

Brighton  
240 Grandview Drive  
Brighton, TN 38011  
Tel: (901) 475-0678

## WELCOME TO GI SPECIALISTS

Thank you for choosing GI Specialists, PC. Our physicians and clinical staff are dedicated to providing the highest quality health care for all our patients and to operating our practice under the strictest ethical business standards. Our main office and surgery center is located at 80 Humphreys in the Baptist Medical Center, and we have satellite offices in Bartlett, Covington, Millington and Brighton.

While receiving treatment at our clinic, your doctor may decide that a diagnostic test or procedure is medically necessary in order to reach a proper diagnosis of your illness. To that end, we offer onsite CT (Cat Scan) and Ultrasound, as well as a fully licensed Ambulatory Surgery Center.

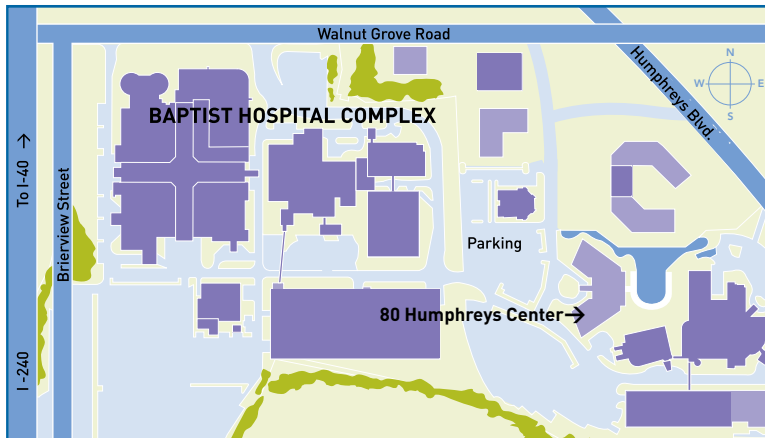
The enclosed packet will provide you with information and some forms we need for you to complete prior to your first visit. The information you give us about your medical history and your current condition will help us to more effectively provide treatment. Completing these forms prior to your first visit will also shorten your wait time.

If you should have any questions prior to your visit, please feel free to call our office at (901) 761-3900 or visit us on the web at [gispecialistsmemphis.com](http://gispecialistsmemphis.com).

Sincerely,

*GI Specialists' Physicians and Staff*

For driving directions, please go to [www.gispecialistsmemphis.com/contact.html](http://www.gispecialistsmemphis.com/contact.html)



## PATIENT INFORMATION

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PLEASE FILL THIS FORM OUT COMPLETELY. PLEASE PRINT CLEARLY.

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female SSN \_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed  Partner Race \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**email address** \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

Spouse / Relative \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's / Relative's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's SSN \_\_\_\_\_

Emergency Contact (not spouse) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

Best way to reach you regarding test or appointment cancellations  Home  Work  Cell  email

May we leave a message?  Home  Work  Cell

### INSURANCE INFORMATION

Primary \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Policy Holder's ID Number \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Insurance Group Number \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION

Insurance \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Policy Holder's ID Number \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Insurance Group Number \_\_\_\_\_

PLEASE PRESENT YOUR INSURANCE CARD(S) AT THE FRONT DESK WITH THIS COMPLETED FORM.

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Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

**SYSTEMS REVIEW**    Please circle YES or NO for each question.

**CONSTITUTIONAL SYMPTOMS**

Headache	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue/Tired	No	Yes
Night Sweats	No	Yes

**CARDIOVASCULAR**

Heart trouble	No	Yes
Chest Pain	No	Yes
Chest tightness	No	Yes
Pain in legs	No	Yes
Swelling feet/hands	No	Yes
Palpitations (racing)	No	Yes
High Blood Pressure	No	Yes

**RESPIRATORY**

Chronic cough	No	Yes
Frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
With walking	No	Yes
Lying flat	No	Yes

**GASTROINTESTINAL**

Loss of appetite	No	Yes
Nausea/vomiting	No	Yes
Abdominal pain	No	Yes
Heartburn / Reflux	No	Yes
Peptic ulcer	No	Yes
Excess gas, bloating	No	Yes
Difficulty swallowing	No	Yes
Change in bowel habits	No	Yes
Diarrhea	No	Yes
Painful bowel movement	No	Yes
Constipation	No	Yes
Blood in stool	No	Yes
Rectal Bleeding	No	Yes

**PSYCHIATRIC**

Memory loss/confusion	No	Yes
Anxiety	No	Yes
Depression	No	Yes
Insomnia / Difficulty sleeping	No	Yes

**MUSCULOSKELETAL**

Joint pain / stiffness	No	Yes	_____
Muscle weakness /cramps	No	Yes	_____
Back pain	No	Yes	(body area)
Neck pain	No	Yes	
Cold extremities	No	Yes	
Arthritis	No	Yes	

**SKIN**

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair/nails	No	Yes
Varicose veins	No	Yes

**NEUROLOGICAL**

Dizziness	No	Yes
Fainting spells	No	Yes
Blurred/cloudy vision	No	Yes
Convulsion/seizures	No	Yes
Numbness/tingling	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes

**HEMATOLOGIC/LYMPATHIC**

Easy bruising	No	Yes
Prolonged bleeding	No	Yes
Anemia (low blood count)	No	Yes
Past blood transfusion	No	Yes
Abnormal blood clotting	No	Yes
Hemophilia	No	Yes

**GENITOURINARY**

Frequent urination	No	Yes
Burning urination	No	Yes
Blood in urine	No	Yes
Incontinence (loss of control)	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes

Are you experiencing any symptoms not on this list?

\_\_\_\_\_ (over)

Patient Name \_\_\_\_\_

**ALLERGIES** (please circle any that apply)

None Penicillin Aspirin Sulfa  
 Iodine Eggs Latex Contrast Dye  
 Other \_\_\_\_\_

**PAST & CURRENT ILLNESSES** (please circle all that apply)

Asthma Cirrhosis Colon Polyps Crohn's Disease  
 Diverticulitis GERD Gallstones Hernia  
 Hepatitis Irritable Bowel Pancreatitis Stomach Ulcer  
 Ulcerative Colitis Parkinson's Disease Seizures Stroke  
 Cancer (type) \_\_\_\_\_ Blood Transfusions Thyroid Disease Pneumonia  
 HIV/AIDS Sexually Transmitted Diseases Tuberculosis Arterial Blockages  
 Heart Failure High Blood Pressure High Cholesterol Rheumatic Fever  
 Fibromyalgia Lupus Melanoma Osteoporosis  
 Urinary Infection Kidney Disease/Failure Ovarian Cysts Diabetes  
 Other: \_\_\_\_\_

**PLEASE LIST PREVIOUS OPERATIONS / TREATMENTS** \_\_\_\_\_

<p><b>How would you rate your general health?</b>  <input type="checkbox"/> Good    <input type="checkbox"/> Fair    <input type="checkbox"/> Poor</p>	<p><b>Do you Smoke?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No                  If yes, how much?</p>	<p><b>Do you drink alcohol?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No                  If yes, how much?</p>
<p><b>Have you ever had a drug abuse problem?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No                  If yes, what type?</p>	<p><b>Have you ever been exposed to HIV (AIDS)?</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No  <input type="checkbox"/> Not sure</p>	

**FAMILY HISTORY**

Have any blood relatives had the following (Father, Mother, Sister, Brother, Child(ren):

Heart Problems                      No    Yes    Who: \_\_\_\_\_  
 Celiac Disease                      No    Yes    Who: \_\_\_\_\_  
 Colitis                                      No    Yes    Who: \_\_\_\_\_  
 Crohn's Disease                      No    Yes    Who: \_\_\_\_\_  
 Liver Disease                          No    Yes    Who: \_\_\_\_\_  
 Colon Polyps                          No    Yes    Who: \_\_\_\_\_  
 Stroke                                      No    Yes    Who: \_\_\_\_\_  
 Cancer                                      No    Yes    Who/Type : \_\_\_\_\_  
 (Breast, Colon, Ovarian, Pancreatic, Stomach, other)  
 Other Chronic Disease              No    Yes    Who: \_\_\_\_\_

The following is a statement of our financial policy which you will need to read and sign prior to receiving any services. We also require all patients to give us complete demographic and insurance information prior to or upon arrival at our offices.

## FOR PATIENTS WITH INSURANCE COVERAGE, INCLUDING MEDICARE OR MEDICAID

We accept assignment of insurance benefits. We will file a claim with your insurance company for any services you receive. The balance of your account after insurance pays is your responsibility. We cannot bill your insurance company without your insurance information and a copy of your insurance card(s). You are responsible to inform us if you have more than one insurance carrier and which carrier is primary and which is secondary. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 120 days of the date of service, the balance will be automatically transferred to you.

Each insurance plan has different policies about how often services may be provided and where they may be performed. We strongly urge you to be familiar with your policy benefits, especially which outside lab to use, and whether you can have radiology services in our office.

## PATIENT RESPONSIBILITY

All co-pays required by your insurance company must be paid at the time of your appointment. This payment is a requirement by your insurance company.

All co-insurance and deductible amounts must be paid within 30 days of your insurance payment or determination of your benefits by your insurance carrier.

If your insurance coverage changes for any reason, it is your responsibility to inform our office and to provide any new insurance information along with a copy of your new card.

## FOR PATIENTS WITHOUT INSURANCE COVERAGE

If you do not have insurance coverage, payment for services is expected at the time services are rendered. Our policy is to reduce the rated charged to uninsured patients to approximately the amount that would be allowed by private insurance. We are happy to set up a payment plan with you.

## FOR PATIENTS UNDER WORKERS' COMPENSATION

We accept assignment of insurance benefits for patients covered under workers' compensation. We will file a claim with the insurance company for any services you receive. We cannot bill the insurance company unless you give us the information and a contact to call to obtain authorization for services. You are responsible to inform us if your visit is related to a workers' compensation injury.

## FOR PATIENTS INVOLVED IN AN AUTOMOBILE OR OTHER ACCIDENT

We accept assignment of insurance benefits for patients involved in an auto accident. We will file a claim with your health insurance company for any services you receive. It is your health insurance company's responsibility to subrogate the claim with your auto insurance or any other party responsible for the accident. [\(over\)](#)

The physicians and staff of Gastrointestinal Specialists, P.C. are pleased that you have chosen us for your GI care. Following is some important financial information, please review it carefully.

After your office visit, your physician may decide that the most effective way to diagnose your condition is to perform a procedure called a **scope**. Your procedure may be scheduled at the **Medical Center Endoscopy Group Surgery Center** located inside our office. When you have a procedure performed there, you will receive the following:

1. A separate bill from **Medical Center Endoscopy Group**, representing the charges for their group only. (This is called a facility charge). If your insurance requires a co-pay, you will receive a phone call from the surgery center prior to your procedure, asking you to bring your co-pay on the day of your procedure. This payment will be applied to the **Medical Center Endoscopy Group** bill. Again, this bill and co-pay is separate from **Gastrointestinal Specialists, P.C.**'s billing.
2. A separate bill from **Gastrointestinal Specialists, P.C.** representing the charges for
  - the physician's charge for performing the procedure(s)
  - the anesthesiologist's charge for your sedation
  - a bill for the pathologists who examines your tissue (if a specimen is taken)

Your insurance typically covers all of these charges minus your co-pay and deductible.

Please call (901) 761-3900 with questions about your bill from Gastrointestinal Specialists, P.C.

Please call (901) 871-0255 with questions about your bill from Medical Center Endoscopy Group.

# PATIENT REPRESENTATIVE IDENTIFICATION FORM

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Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Chart Number \_\_\_\_\_

By law, the HIPAA Privacy Rule prohibits Gastrointestinal Specialists, P.C. from disclosing your **Protected Health Information (PHI)** to anyone without your authorization, except for treatment, payment, and health care operations. This rule became effective April 14, 2003.

Please list the names of all persons that you wish to have access to your Protected Health Information (PHI):

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Please list the name of the person(s) with whom we can discuss your bill:

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

If applicable, please list the name of your **Legal Representative**:

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Please Check One:** by what authority is this person your Legal Representative?

\_\_\_\_\_ Next of Kin

\_\_\_\_\_ Guardian

\_\_\_\_\_ General Power of Attorney

\_\_\_\_\_ Health Care Power of Attorney

In order for us to disclose your Protected Health Information, the above representatives must be able to provide two (2) of the three (3) identifiers listed below:

- Patient's social security number
- Patient's date of birth; or
- Patient's zip code

\_\_\_\_\_  
Patient or Patient Representative Signature

\_\_\_\_\_  
Date



## CONSENT FOR TREATMENT BY PARENT FOR MINOR

Paul S. Bierman, MD  
Kenneth I. Fields, MD  
Gerald J. Lieberman, MD  
Edward S. Friedman, MD

## CONSENT FOR TREATMENT UNDER GUARDIANSHIP

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Patient Name: \_\_\_\_\_

Patient Age (if minor) \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize the physicians of Gastrointestinal Specialists, P.C. to provide such medical services including surgery, if necessary, either scheduled or emergency as may be determined to be in the best interest of patient, \_\_\_\_\_.

This authorization shall continue and be effective until revoked in writing by me.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

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Your feedback is important to us. Please rate your experience while receiving care at this facility. Mark or circle one response that best describes your experience. Please return to a staff member or survey drop box. Thank you!

Are you: (check one)  the patient    family member, friend, support provider, etc.

Please select your visit type:  office visit    procedure    Ultrasound    other

**PLEASE RATE THE FOLLOWING ASPECTS OF YOUR EXPERIENCE HERE:**

	Excellent	Very Good	Good	Fair	Poor	Not Applicable
1. The overall quality of care you received at this office.	E	VG	G	F	P	N/A
2. Ease of getting an appointment time that was convenient for you.	E	VG	G	F	P	N/A
3. Friendliness of staff who took your registration and insurance information.	E	VG	G	F	P	N/A
4. How well the staff explained your procedure to you.	E	VG	G	F	P	N/A
5. How attentive the staff were to your needs.	E	VG	G	F	P	N/A
6. How well we met your expectations for timely care.	E	VG	G	F	P	N/A

Would you recommend us to a friend or family member:  yes    maybe    no

Overall, were you treated well during your visit today?  very good    fair    poor

If we have further questions, may we call you to talk about your experience here?  yes    no

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

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

What could our office have done to make the experience for you and your family better?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## GIS IMAGING NOTIFICATION

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During the course of your care, the physicians of Gastrointestinal Specialists, PC may order imaging (radiology) tests be performed to aid in the diagnosis and/or treatment of your disease. Therefore, you may be referred to the Gastrointestinal Specialists' Imaging Department for these tests as approved by your insurance.

The new Healthcare Reform Bill, known as the Patient Protection and Affordable Care Act, requires physicians who provide imaging services for their Medicare patients to inform the patients in writing that they may obtain these services somewhere else. They are also required to provide a written list of other suppliers or imaging centers that perform these tests.

To meet this requirement, please refer to the attached list of radiology/imaging centers offering these services.

If you wish to have the test(s) done at one of these centers instead of at Gastrointestinal Specialists, PC, we will be glad to make your appointment at the facility of your choice.

We do not make any representation about the quality of the services offered by these other centers.

\_\_\_\_\_  
Patient Name (Please Print)

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

\_\_\_\_\_  
Date

# Imaging Suppliers

## East Arkansas

## North Memphis

*(Includes Bartlett, Millington, Tipton & Lauderdale Counties)*

## East Memphis

## DeSoto County, MS

## North East Mississippi

**Outpatient Radiology Clinic**  
200 S. Rhodes Street, Suite B  
West Memphis, AR 72301  
(870) 735-5555

**Methodist Diagnostic Center**  
3950 New Covington Pike  
Memphis, TN 38128  
(901) 516-5550

**Methodist Diagnostic Center**  
1377 S. Germantown Road  
Germantown, TN 38138  
(901)516-6777

**DeSoto Imaging Specialists**  
7420 Guthrie Drive North  
Suite 105  
Southaven, MS 38671  
(662) 349-4321

**Oxford Diagnostic Center - Oxford**  
501 Azalea Drive  
Oxford, MS 38652  
(662) 513-1699  
Fax : (662) 513-9634

**Diagnostic Imaging Associates**  
310 S. Service Road  
West Memphis, AR 72301  
(870) 732-2401

**Diagnostic Health Memphis**  
5130 Stage Road  
Memphis, TN 38134  
(901) 385-2636

**Diagnostic Imaging**  
6401 Poplar Avenue, Suite 100  
Memphis, TN 38119  
(901) 387-2340

**Carvel Imaging**  
9085 Sandidge Center Cove  
Olive Branch, MS 38654  
(662) 536-1000

**Longtown Imaging Center - Tupelo**  
4381 South Eason Blvd.  
Tupelo, MS 38801  
(662) 377-5115  
Tax ID: 640662976

## Memphis Metro

**Methodist Diagnostic Center**  
1801 Union Avenue.  
Memphis, TN 38104  
(901) 772-3131

**Mid-South Imaging & Therapeutics**  
6305 Humphreys Blvd.  
Memphis, TN 38120  
(901) 747-1000

**Harper Road Imaging - Corinth**  
2421 Proper Street  
Corinth, MS 38834  
(662) 287-0376

**Total Care Outpatient Imaging Center**  
6005 Park Avenue  
O’Ryan Building # 100B  
Memphis, TN 38119  
(901) 761-5320

**Carvel Imaging**  
7400 Airways Blvd.  
Southaven, MS 38671  
(662) 536-1000

**Magnolia Regional Health Center - Corinth**  
611 Alcorn Drive  
Corinth, MS 38834  
(662) 293-1026  
Tax ID: 640428003

**West TN Imaging - Jackson**  
300 Post Land  
Jackson, TN 38301  
(731) 541-8850

## COLONOSCOPY PREPARATION

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The key to an accurate diagnosis is a proper preparation. The bowel needs to be flushed completely free of waste material to give your doctor the clearest possible view. The thoroughness of this intestinal cleansing depends on you. Without your cooperation the examination cannot accomplish its purpose and may have to be repeated.

### **NOTHING TO EAT OR DRINK AFTER MIDNIGHT THE NIGHT BEFORE THE PROCEDURE!**

If you are scheduled for a late morning or afternoon appointment you may have clear liquids only up until 3 hours prior to your procedure.

### **PLEASE FOLLOW THESE INSTRUCTIONS:**

Purchase (1) 255 gram bottle of Miralax (prescription). (2) Dicolax and (1) 64 oz. of chilled Gatorade Ice (or two 32oz) from your pharmacy or grocery store.

**ONE WEEK BEFORE COLONOSCOPY:** NO ASPIRIN, ADVIL, MOTRIN, IBUPROFEN, ALEVE, IRON, VIOXX, CELEBREX OR ASPRIN PRODUCTS. PLEASE INFORM US IF YOU ARE USING COUMADIN, WARFARIN, PLAVIX OR ANY OTHER BLOOD THINNERS. YOU MAY USE TYLENOL. Do not eat corn until after the procedure.

**ONE DAY BEFORE THE PROCEDURE:** clear liquids for the entire day. Clear liquids include: white cranberry and apple juice, 7up, ginger ale, tea, clear thick broth without noodles and plain jello (NOT RED!)

AT 3:00 PM TAKE (2) DULCOLAX TABLETS WITH 8 oz OF WATER; swallow tablets whole and drink the full glass of water.

AT 5:00 pm mix the 255 gram bottle of Miralax in 64 oz of Gatorade Ice (or two 32oz bottles) NO RED OR PURPLE! and shake the solution until the Miralax is dissolved. Drink an 8 oz glass of the mixture every 10-15 minutes until solution is gone.

### **CLEAR LIQUIDS YOU MAY HAVE:**

APPLE JUICE	WHITE GRAPE JUICE	WHITE CRANBERRY JUICE		
ANY COLA DRINKS	CLEAR CHICKEN BROTH	CLEAR BEEF BROTH		
light colored KOOL-AID	light colored GATORADE	WATER		
JELLO (no red)	TEA	COFFEE (no cream)		
NO MILK	NO ORANGE JUICE	NO PRUNE JUICE	NO TOMATO JUICE	NO SOLID FOODS

**YOU MUST BRING SOMEONE TO DRIVE YOU HOME AFTER YOUR TEST  
OR YOUR TEST WILL BE POSTPONED!**

The day of your test: come to 80 Humphreys Center Drive, Suite 200 at \_\_\_\_\_ with an empty stomach.

You may only take medications that you routinely take, such as seizure, high blood pressure, breathing, heart and behavioral medications with a sip of water. Please bring all of your medications with you to your test.

**You should expect to be here 3 to 4 hours. Please call (901) 881-5571 to reschedule.**