Gastroenterology Associates of Pittsburgh
T. Jan Ravi, M.D.
Andrew W. Thomas, M.D.
Frank J. Koziara, II M.D.
3285 Babcock Blvd
Pittsburgh, PA 15237-2829

Phone: (412) 318-0075 Fax: (412) 318-0081

PLEASE READ ALL OF THE INSTRUCTIONS BEFORE BEGINNING THE TEST PREPARATION

THESE DIRECTIONS ARE FOR: Colonoscopy

OR

Colonoscopy/Endoscopy on the same day

You are scheduled at **ALLEGHENY HEALTH NETWORK, WEXFORD SURGERY CENTER** – 12311 Perry Highway, Wexford, PA 15090. Enter this facility through the main entrance and take the main elevators to the 2nd floor. If you are unable to keep this appointment for any reason, please notify our office at 412/318-0075.

DAY BEFORE THE TEST: NO SOLID FOOD (unless otherwise noted by the physician)!!! DRINK ONLY CLEAR LIQUIDS!!! **YOU MAY CONTINUE TO HAVE CLEAR LIQUIDS UNTIL 6 HOURS PRIOR TO YOUR ARRIVAL TIME.**

CLEAR LIQUID DIET LIST

BEVERAGES/SOUPS/DESSERTS

Water, tea or coffee (no milk or non-dairy creamer) - Adding sweeteners is okay
Low sodium chicken or beef bouillon/broth
Hard candies - NO RED or PURPLE
Soft drinks (7-up, cola, ginger ale, Sprite), Gatorade, Kool-aid, lemonade – NO RED or PURPLE
Jell-O (lemon, lime or clear) – No fruit toppings/NO RED or PURPLE
Strained fruit juices without pulp (i.e. apple, white cranberry, white grape)
Popsicles - No sherbets or fruit bars/NO RED or PURPLE

ON THE DAY OF YOUR TEST: Take all of your medications except those listed below. Use as little water as possible and take your medications as early as possible.

FIVE DAYS PRIOR TO YOUR TEST: DO NOT TAKE iron pills or medications that can cause bleeding such as Coumadin (Warfarin), Plavix,325 mg Aspirin (It is ok to take 81 mg baby Aspirin.), or Alka-Seltzer. If you are taking a blood thinner medication that is not mentioned above, please stop this medication five days prior to the test. You must also stop Pepto-Bismol.

TWO DAYS PRIOR TO YOUR TEST: Discontinue ALL fiber supplements, which would include Metamucil, Citrucel, Fiberall, Benefiber, etc. AVOID foods with small seeds such as tomatoes, sesame seeds, kiwi and cucumbers.

DIABETICS: Please contact your primary care physician for instructions on how to take your diabetes medication.

It is very important to drink liquids during the bowel preparation process. You will lose a significant amount of fluid, which is normal. It is very important that you replace this fluid to prevent dehydration.

No laxative preparation is fun. You must complete all of the preparation for the test. If you are unable, contact our office to reschedule your appointment. Your test will be cancelled if your preparation is inadequate. Please follow each instruction exactly as written.

NO DRIVING: You cannot drive, use a taxi, or a bus after the procedure. You must be accompanied by an adult who must remain with you at the hospital while your procedure is being done. According to the hospital regulations, someone must remain with you after the procedure for 24 hours. If you cannot make these arrangements, please notify the office and we will reschedule your appointment.

For women, if you are having a menstrual period, it is ok to wear a tampon.

Gastroenterology Associates of Pittsburgh

SUPREP Instruction Sheet

You will need to purchase: SUPREP Prep Kit
4 Dulcolax tablets (GENERIC: Bisacodyl - over the counter)

WHAT TO DO THE DAY BEFORE YOUR COLONOSCOPY

You must stay on a clear liquid diet all day! Do not eat solid foods.
Clear Liquids ONLY: Please see attached list provided before this instruction sheet.

THIS PREP IS A SPLIT DOSE REGIMEN - 2 SEPARATE DOSING TIMES

At **5:00 PM** follow Steps 1 - 4 below using (1) 6-ounce bottle

Step 1
Pour ONE (1) 6-ounce bottle of SUPREP liquid into the mixing container.
Step 2
Add cool drinking water to the 16-ounce line on the container and mix.
Step 3
Drink ALL the liquid in the container.
Step 4
IMPORTANT: You must drink two (2) more 16-ounce containers of water over the next 1 hour.

You may drink clear liquids after your second glass of water.

At **8:00 PM** – Take 4 Dulcolax (GENERIC: Bisacodyl) Tablets

Please continue to drink plenty of clear liquids.

7 HOURS PRIOR TO YOUR ARRIVAL TIME - Repeat **Steps 1-4** as directed above.

IT'S IMPERATIVE THAT YOU FINISH the 2nd dose of this prep within 1 hour

YOU MAY CONTINUE TO DRINK CLEAR LIQUIDS UNTIL 6 HOURS PRIOR TO PROCEDURE ARRIVAL TIME.

WE REALIZE THAT YOU HAVE TO GET UP EARLY IN THE MORNING TO FINISH YOUR PREP. THIS IS TO ENSURE THAT YOUR COLON IS COMPLETELY CLEAN, SO THE DOCTOR IS ABLE TO VISUALIZE ALL WALLS OF THE COLON & ANY ABNORMALITIES.
(We don't want you to have to repeat the colon preparation a second time.)

YOU MUST DRINK THIS PREP AT THE TIMES INDICATED ABOVE.

Please complete & bring with you the

next 12 pages

of attached information to your appointment

GASTROENTEROLOGY ASSOCIATES OF PITTSBURGH
HEALTH HISTORY FORM - PRE/OP VISIT
DR. T. JAN RAVI
DR. ANDREW W. THOMAS
DR. FRANK J. KOZIARA, II
KRISTEN M. ZON, PA-C
ANNA BRUNETTE, PA-C

Today's Date: _____/_____/_____

Name:_____DOB:_____AGE:_____SS#:_____Marital status:_____

Chief Complaint:_____

How long have you had this problem? _____

FOR PATIENT USE:

Please check off any problems or symptoms

____ **Mitral Valve Prolapse**
____ **Rheumatic Fever**
____ **Diabetes**
____ **Hypertension**
____ **Congestive Heart Failure**
____ **Chest Pain/Angina**
____ **Heart Attack**
____ **Anxiety**
____ **Fatigue**
____ **Gallbladder**
____ **Gastric/Duodenal Ulcer**
____ **Liver Disease**
____ **Gastric Polyps**
____ **Colon Polyps**
____ **Difficulty Swallowing**
____ **Weight loss/gain**
____ **Rectal Bleeding**
____ **Constipation**
____ **Diarrhea/Loose Bowels**
____ **Rectal Pain**
____ **Nausea**
____ **Vomiting**
____ **Indigestion/Heartburn**
____ **Hemorrhoids**
____ **Anemia**
____ **Change in bowel habits**

Have you had any previous testing for the above problems or symptoms?

_____

_____

_____

_____

_____

FOR DOCTOR'S USE:

Weight:_____Height:_____ B/P:_____
General Appearance:_____
Temperature:_____

PHYSICIAN REVIEW COMMENTS ON CC:
PHYSICIAN REVIEW COMMENTS ON PMH:
(HPI: LOCATION, QUALITY, SEVERITY, DURATION,TIMING, CONTEXT, MODIFYING FACTORS, ASSOC SIGNS/SYMPTOMS)

_____

_____

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_____

_____

NAME:_____**DATE:**_____

FOR PATIENT USE:

PAST SURGICAL HISTORY:

_____

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_____

PAST MEDICAL HISTORY:

_____

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PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING:

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FOR DOCTOR'S USE:

PHYSICIAN COMMENTS ON PSH:

_____

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PHYSICIAN COMMENTS ON PMH:

_____

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PHYSICIAN REVIEW OF MEDICATIONS:

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NAME:_____**DATE:**_____

ALLERGIES TO MEDICATIONS

_____

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PHYSICIAN REVIEW OF PATIENT ALLERGIES:

_____

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_____

SOCIAL HABITS:
Smoke: Packs daily_____How long?____
Caffeine:_____
Drugs/Alcohol use"_____
Sleep pattern_____

PHYSICIAN REVIEW OF SOCIAL HABITS:

_____

_____

FAMILY HISTORY:

_____

_____

PHYSICIAN REVIEW OF FAMILY HISTORY

_____

_____

FOR DOCTOR'S USE: (staff or patient may document)

REVIEW OF SYSTEMS: (+, -, OR NA)

_____ EYES **• Visual Disturbances**	**___No**	**___Yes**	**ABNORMAL**
_____ ENT **• Auditory disturbances** **• Sinus Problems**	**___No** **___No**	**___Yes** **___Yes**	**ABNORMAL**
_____ CARDIO **• Hypertension** **• Palpitations** **• Chest pain** **• Rheumatic fever** **• Murmurs** **• Mitral Valve Prolapse**	**___No** **___No** **___No** **___No** **___No** **___No**	**___Yes** **___Yes** **___Yes** **___Yes** **___Yes** **___Yes**	**ABNORMAL**
_____ RESP **• Shortness of Breath** **• Asthma** **• Sleep Apnea** **• Cough**	**___No** **___No** **___No** **___No**	**___Yes** **___Yes** **___Yes** **___Yes**	**ABNORMAL**
_____ GU **• Frequency** **• Dysuria** **• Incontinence** **• PSA**	**___No** **___No** **___No** **___No**	**___Yes** **___Yes** **___Yes** **___Yes**	**ABNORMAL**
_____ GI **• As per presenting problem**	**ABNORMAL**		
_____MUSCULOSKELETAL **• Muscle Pain or Weakness** **• Joint Pain**	**___No** **___No**	**___Yes** **___Yes**	**ABNORMAL**
_____ SKIN **• Rashes or itching**	**___No**	**___Yes**	**ABNORMAL**

NAME:_____DATE:_____

_____ NEURO/PSYCH **• Headaches** **• Seizures** **• CVA's** **• Depression** **• Anxiety** **• Sleep Disturbances**	 **___No** **___No** **___No** **___No** **___No** **___No**	 **___Yes** **___Yes** **___Yes** **___Yes** **___Yes** **___Yes**	**ABNORMAL**
_____ HEME **• History of transfusions** **• Anemia** **• Bleeding problems**	 **___No** **___No** **___No**	 **___Yes** **___Yes** **___Yes**	**ABNORMAL**
_____ GENERAL **• Weight loss** **• Decreased appetite** **• Fever/night sweats/chills**	 **___No** **___No** **___No**	 **___Yes** **___Yes** **___Yes**	**ABNORMAL**
_____GYN **• Endometriosis** **• LMP** **• Mammogram/PAP**	 **___No** **___No** **___No**	 **___Yes** **___Yes** **___Yes**	**ABNORMAL**

PHYSICAL EXAMINATION:

EYES		**CLEAR CONJUNCTIVA, ANIECTERIC SCLERA, PEARLLA**		**ABNORMAL:**
EARS, NOSE, THROAT		**TM'S INTACT, NO PHARYNGEAL CONGESTION**		**ABNORMAL:**
NECK		**SUPPLE, NO MASSES, THYROID WITHIN NORMAL LIMITS, PALPABLE CAROTID ARTERIES, NO BRUITS**		**ABNORMAL:**
GASTROINTESTINAL		**ABD SOFT – NON-TENDER, NORMO-ACTIVE BOWEL SOUNDS, NO ORGANOMEGALY, ABNORMAL PULSATIONS OR MASSES, NO INGUINAL HERNIA OR LYMPHADENOPATHY, GOOD SPHINCTER TONE, NO MASSES/ HEMORRHOIDS, TENDERNESS OR ASCITES**		**ABNORMAL:**
CARDIOVASCULAR		**REG RATE/RHYTHM, NO MURMURS, RUBS/GALLOPS, EXTERMITIES – NO CLUBBING/ CYANOSIS OR EDEMA**		**ABNORMAL:**
RESPIRATORY		**LUNGS CLEAR TO AUSCULTATION/PERCUSS, GOOD AIR EXCHANGE, SYMMETRICAL, EXCUSION**		**ABNORMAL:**
PSYCH/NEURO		**AWAKE, ALERT, ORIENTED / PATIENT'S JUDGEMENT & INSIGHT, MOOD, CRAINIAL NERVES GROSSLY INTACT**		**ABNORMAL**
SKIN		**WITHOUT RASHES, LESIONS, ULCERS, NODULES, GOOD SKIN TURGOR**		**ABNORMAL**
LYMPHATIC SYSTEM		**EXAMINATION OF ORGANS AND NODES**		**ABNORMAL**
ALL OTHERS NEGATIVE				**ABNORMAL**

NAME:_____**DATE:**_____

FOR DOCTOR'S USE:

DIAGNOSIS: _____

_____

_____

_____

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TOTAL TIME:_____

COUNSELING:_____
FACE TO FACE

PLAN: _____

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ATTENDING SIGNATURE:_____**DATE:** _____

GASTROENTEROLOGY ASSOCIATES OF PITTSBURGH

T. Jan Ravi, M.D.
Andrew W. Thomas, M.D.
Frank J. Koziara, II M.D.
Kristen M. Zon, PA-C
Anna Brunette, PA-C

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

The terms of this Notice of Privacy Practices apply to Gastroenterology Associates of Pittsburgh, PC. The privacy practices described in this notice are followed by employees, doctors, other professionals or volunteers who serve you at our locations including:

-3285 Babcock Blvd, Pittsburgh, PA 15237
-3 St. Francis Way, Building 3-Suite 211, Cranberry Twp., PA 16066

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of the Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notices at any service location or a copy may be obtained on our web site at **www.gastroenterologyassociatesofpittsburgh.com** or by mailing a request to any of our offices listed above.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION:

Your Authorization: Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization. There will be certain uses and disclosures of your personal health information for which we will always obtain a prior authorization and these include:

-Uses and Disclosures for Treatment: We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, test, etc. We may also release your personal health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you.

-Uses and Disclosures for Payment: We will make uses and disclosures of your personal health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your medical

procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

-Uses and Disclosures for Health Care Operations: We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

-Family and Friends Involved In Your Care: With your approval, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individual's without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

-Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

-Fundraising: We may contact you to donate to a fundraising effort for or on our behalf. You have the right to "opt-out" of receiving fundraising materials/communications and may do so by sending your name and address to the Privacy Officer together with a statement that you do not wish to receive fundraising materials or communications from us.

-Appointments and Services: We may contact you to provide appointment reminders or test results. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. You may request such confidential communications in writing and may send your request to the Privacy Officer.

-Health Products and Services: We may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

-Research: In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a researcher may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or Privacy Board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

-Other uses and disclosures: Those not described in this notice will be made only with your written authorization including: psychotherapy notes, for marketing purposes, or the sale of your protected health information. You may revoke such authorization by informing us in writing of you r request.

-**Federal Law.** Federal law permits use or disclosure of your health information without obtaining individual authorization for certain administrative activities of our facility that is necessary and/or required. These activities include reports: of public health activities such as the state or federal government (e.g., deaths, births, disease/injury reports, child abuse or neglect, adverse events); to employers in certain situations (e.g.; for workplace medical or injury/illness evaluation); of victims of abuse; neglect or domestic violence; for health oversight activities authorized by law (e.g., audits or inspections); for legal or administrative proceedings (e.g.; compliance review, court orders); to law enforcement; about decedents (e.g.; coroner, medical examiner, funeral director); about organ donation; for workers' compensation benefits, and for research when an approved authorization waiver is obtained.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

-**Requesting restrictions on Use and Disclosure**. You have the right to request in writing that we restrict the use and disclosure of your health information for treatment, payment, or health care operations. We are not required to agree to your restriction request except when the restriction request pertains to a disclosure to a health plan for purposes of carrying out payment or health care operations when the information pertains solely to a healthcare service for which we have been paid out of pocket in full by you. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. You also have the right to terminate, in writing, any agreed-to restriction by sending such notice to one of our offices.

-**Receiving confidential communications related to your health information**. You have the right to specify other ways or locations you receive confidential communications from Gastroenterology Associates of Pittsburgh, PC about your health information.

-**Accessing and copying your health information**. In most cases, you have the right to review or obtain a copy of your health information maintained by our office. You have a right to obtain an electronic copy of your health information that exists in an electronic format and you may direct that the copy be transmitted directly to the entity or person designated by you provided that any such delegation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. All requests for access must be made in writing and signed by you or your representative. If you request a copy of your health information, we may charge a fee for the cost of copying and mailing this information to you.

-**Requesting amendments to your health information**. You may ask that we amend any of you health information if you believe it is incomplete of incorrect. An amendment requests must be in writing. We are not obligated to make all requested amendments but will give each careful consideration. You must give us the reason why you are asking for the change. We may deny your request if the information was not created Gastroenterology Associates of Pittsburgh, PC, is not part of your medical record maintained by Gastroenterology Associates of Pittsburgh, PC, or if we find you health information already documented is accurate and complete. If we deny your request, we will inform you in writing. You have the right to respond to us if you do not agree with the denial decision.

-**Accounting for disclosures of your personal health information.** You have the right to receive an accounting of disclosures made by us of your personal health information up to six years prior to the date of your request. Requests must be in writing and signed by you or an authorized representative of yours.

You may be charged a fee if you request more than one accounting within the same 12 month period. We're not required to list disclosures related to treatment, payment and healthcare operations; facility directory listings; involvement of family or friends in you care; correctional institutions, or any disclosure for which you gave you written authorization.

-**Breach Notification**. In the unlikely event that there is a breach or unauthorized release of you personal health information, you will receive notice and information on steps you may take to protect yourself from harm. We will notify you promptly of the occurrence and provide you with details regarding the information that was breached.

-**Complaints**. If you want to make a written request regarding your protected health information or think we may have violated you privacy rights and want to file a complaint, please contact us at one of our offices. You have the right to send a written complaint to the United States of Health and Human Services Office of Civil Rights.

-**Acknowledgement of Receipt of Notice.** You will be asked to sign an acknowledgement from that you received this Notice of Privacy Practices.

-**Further information and Requests**. If you have questions or need further assistance regarding this Notice, or wish to exercise any of the rights stated in this Notice, you may contact one of our above listed offices and request to speak to with the Privacy Office of our facility.

As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such a copy by e-mail or other electronic means.

Gastroenterology Associate of Pittsburgh, PC is required to follow the privacy practices described in this notice as of the effective date. We have the right to change our notice and apply new privacy practices to any of your health information that we maintain. We will make the revised notice available on its effective date. You may receive a revised notice by requesting one during your visit.

EFFECTIVE DATE:
The Notice of Privacy Practices is effective September 23, 2013.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with the HIPAA Compliance Office in person at our main phone number (412) 318-0075.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ Date: _____

GASTROENTEROLOGY ASSOCIATES OF PITTSBURGH

T. Jan Ravi, M.D.
Andrew W. Thomas, M.D.
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Kristen M. Zon, PA-C
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3285 Babcock Blvd, Pittsburgh, PA 15237 – Tele: (412) 318-0075 – Fax: (412) 318-0081
3 St. Francis Way, Building 3 - Suite 211, Cranberry Township, PA 16066 – Tele: (724) 935-8452 – Fax: (412) 318-0081

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A PERSON INVOLVED IN THE PATIENT'S CARE

At Gastroenterology Associates of Pittsburgh, we take every precaution not to disclose protected health information to any entity not involved in your care. We only release protected information for treatment, payment and health operations or that which is required by law. All other disclosures must have an authorization.

To that effect, we understand that there are times when someone involved in your care may call our office requesting information about your care (for example, medications questions or prescription refills). If there is an individual(s) involved in your care to which you give us authorization to release protected health information to, please complete the information below.

Name of individual(s) that we may release health information to and their relationship to you:

Name:	**Relationship:**	**Date of Birth:**	**Phone Number (optional):**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that by signing below, I give authorization to Gastroenterology Associates of Pittsburgh to release protected health information to the above listed individuals.

I also understand that I may revoke this authorization IN WRITING, except to the extent that Gastroenterology Associates of Pittsburgh has taken action in reliance on the authorization at anytime as long as that request is given to the Privacy Officer.

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Gastroenterology Associates of Pittsburgh
3285 Babcock Blvd
Pittsburgh, PA 15237

Phone: (412) 318-0075
(724) 935-8452
Fax: (412) 318-0081

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____Home #: _____

SS#: _____ Male/Female: _____ Marital Status: _____ Spouse: _____

Employer:_____ Work #: _____ Cell #: _____

Email: _____

INSURANCE INFORMATION

PRIMARY INSURANCE
Name of Insurance: _____

Subscriber's Name:_____ Subscriber's DOB: _____

Insurance Address: _____

ID#: _____ Group #:_____

SECONDARY INSURANCE
Name of Insurance: _____

Subscriber's Name:_____ Subscriber's DOB: _____

Insurance Address: _____

ID#: _____ Group #:_____

PRIMARY PHARMACY INFORMATION
Name of Pharmacy: _____ Phone #: _____

Address of Pharmacy: _____

MAIL ORDER INFORMATION
Name of Mail Order Provider: _____

Primary Care Physician	Street Address, City, State, Zip	Phone #
Referred By	Street Address, City, State, Zip	Phone #
Emergency Contact	Relationship	Phone #

I request that payment of authorized benefits be made on my behalf to this provider for any service furnished to me by this physician or supplier. I understand that I am financially responsible for the payment of any deductible amount, co-insurance, copay and any other balance not paid for me by my insurance plan(s). I also authorize the release of information as may be necessary, to the proper insurance carrier to determine benefits.

Signature: _____ Date: _____

ATTENTION PATIENT

Due to the recent changes in our company's Privacy Policies, we are required to ask your permission to leave messages, **regarding upcoming appointments**, on the primary phone number and/or cell phone number you have given Gastroenterology Associates of Pittsburgh.

If this is permitted, please sign, date, and include your primary phone number(s) below.

Patient's Name: _____ DOB: _____

Primary Phone #: _____

Cell Phone #: _____

(Only include if we can leave messages at this number.)

If you are NOT COMFORTABLE with our office leaving detailed appointment or reminder information in a message, please leave the above lines blank and DO NOT SIGN BELOW.

Patient's Signature: _____ Date: _____

Thank you for your cooperation.