M.P. VEERA MD PA
OPEN ACCESS COLONOSCOPY PATIENT INFORMATION SHEET
ADDRESS: 130 PERPETUAL SQUARE, ANDERSON, SC 29621
PHONE: (864)224-8689 FAX: (864)222-1303

DR. M.P. VEERABAGU, M.D
BOARD CERTIFIED IN GASTROENTEROLOGY & INTERNAL MEDICINE

OFFICE HOURS: MONDAY-FRIDAY: 8 AM-12 NOON
MONDAY-THURSDAY: 1 PM -5 PM/CLOSED FRIDAY 12 NOON

PATIENT NAME: _____ **FREE OPEN ACCESS NURSE APPOINTMENT:** _____

***** IF YOU ARE HAVING ANY CHRONIC CONDITIONS OR COMPLAINTS/ SYMPTOMS: FOR EXAMPLE- HISTORY OF COLON POLYPS OR ANY OTHER PROBLEMS, COMPLAINTS, OR SYMPTOMS, YOU WILL NEED TO CONTACT OUR OFFICE PRIOR TO THIS VISIT SO THAT YOU WILL BE RESCHEDULED TO SEE OUR MEDICAL PROVIDER WITHOUT WHICH YOU MAY NEED TO RETURN FOR A PROVIDER APPOINTMENT*****

*****IF POLYPS OR ABNORMALITIES ARE FOUND THAT THE PROVIDER CAN REMOVE DURING YOUR PROCEDURE, YOUR BENEFITS MAY CHANGE AND YOUR INSURANCE POLICY MAY PAY DIFFERENTLY, RESULTING IN ADDED COSTS TO YOU.**

*****IF NONE OF THE ABOVE APPLY AND YOU ARE ABOVE THE AGE OF 50, YOUR PROCEDURE COSTS - PHYSICIAN PROCEDURE FEES, OFFICE VISIT(S) IF ANY, PROCEDURE FACILITY FEES & ANCILLARY SERVICES ARE CONSIDERED BY YOUR INSURANCE AS SCREENING COLONOSCOPY. *IF YOU ARE BELOW THE AGE OF 50* SOME INSURANCE COMPANIES DO NOT COVER A SCREENING COLONOSCOPY. IT IS YOUR RESPONSIBILITY TO VERIFY COVERAGE & GET A REFERENCE/CASE NUMBER.**

***** FOR ANY ANCILLARY FEES NOT RELATED TO MP VEERA MD PA PLEASE SEE BELOW****

PATIENT SIGNATURE: _____ **DATE** _____

WELCOME TO OUR GASTROENTEROLOGY PRACTICE. THIS NURSE VISIT IS A FREE VISIT AND YOUR DESIGNATED TIME SLOT TO MEET OUR CLINICAL STAFF. YOU WILL DROP OFF YOUR COMPLETED REGISTRATION PAPERWORK, PICK UP YOUR COLON PREP INSTRUCTIONS AND PRESCRIPTIONS ALONG WITH YOUR SCHEDULED COLONOSCOPY PROCEDURE DATE AND LOCATION. AND AN OPPURTUNITY TO CLEAR ANY QUESTIONS YOU MAY HAVE REGARDING YOUR PROCEDURE SETUP, COLON PREP INSTRUCTIONS, AND LOCATION ETC.

PLEASE CALL US IF YOU WISH TO MAKE ALTERNATE ARRANGEMENTS REGARDING YOUR NURSE VISIT APPOINTMENT (WE CAN WORK WITH YOUR SCHEDULE) INCLUDING CANCELLATIONS AND RESCHEDULES.

IN ORDER TO PROCEED WITH YOUR OPEN ACCESS COLONOSCOPY, WE NEED YOU TO FOLLOW THESE INSTRUCTIONS:

- COMPLETE AND BRING THE ATTACHED PATIENT REGISTRATION FORMS
- YOUR INSURANCE CARD AND DRIVERS LICENSE PHOTO ID
- YOUR INSURANCE ELIGIBILITY WAS CHECKED ON _____
- ALL CURRENT MEDICATIONS-BOTH PRESCRIPTIONS AND OVER-THE-COUNTER
- **FOR MAIL ORDER PHARMACIES WE NEED THE NAME, ADDRESS, PHONE NUMBER, FAX AND ANY OTHER DETAILS TO SEND IN YOUR ORDERS DURING YOUR OFFICE VISIT.**
- THE LABORATORY NAME AND PHONE # WHERE YOUR INSURANCE COMPANY IS IN NETWORK

TEST RESULTS: THE NATURE AND COMPLEXITY OF THE RESULTS WILL DETERMINE HOW THEY WILL BE REPORTED TO YOU. POSSIBILITIES INCLUDE: OFFICE VISITS, MAIL, TELEPHONE CALL OR PATIENT PORTAL.

OTHER ANCILLARY FEE ESTIMATES NOT RELATED TO MP VEERA MD PA:

FACILITY FEES, ANESTHESIA AND OTHER FEES

AnMed Facility Procedures, Anesthesia and other fees: Call at Anmed Financial Services at 864-512-1417.
Upstate Endoscopy, LLC (Upstate) Facility procedures: Call 864.512.6555.
For Upstate procedure Anesthesia call Anesthesia Services of Anderson, SC @ 864.225.4601
For Upstate procedure's Biopsy Readings, IF NEEDED, taken during procedure will need Pathology services. Please call Piedmont Pathology @ 864-226-1558

****************************FOR EMERGENT MEDICAL NEEDS CALL 911************************************

MP Veera MD PA

Open Access Clinical Questionnaire

Patient Name:_____ Date of Birth:_____

Best Phone#:_____ Alt phone #:_____

Height:_____ Weight:_____ Primary Care Physician:_____

Please review each question carefully. Failure to do so may result in having to reschedule to a different date/time with a provider. PLEASE BE AWARE THAT ANY ABNORMALITIES (POLYPS, LESIONS, CANCER, ETC.) FOUND MAY RESULT IN ADDITIONAL COSTS TO YOU AND MAY NO LONGER BE COVERED UNDER PREVENTATIVE CARE BENEFITS.

Do you have any of the following GI symptoms?:

____ Poor appetite ____Bleeding ____Polyps ____Heartburn

____Weight loss ____Nausea/vomiting ____Difficulty Swallowing

____Diverticulosis ____Abdominal Pain ____Constipation ____Diarrhea

____Dark stools ____Change in bowel pattern ____NONE

Any other symptoms?:

____Fever ____Bleeding problems ____Breathing difficulties

____Chest Pain ____Fainting/dizziness ____NONE

Past Medical History:

____Anemia ____Sleep Apnea/CPAP use ____Seizures

____Cancer ____Diabetes ____Stroke

____Crohn's ____Clotting disorder ____DVT/PE

____Diverticulitis ____Heart issues ____MRSA/VRE

____Liver disease ____Hypertension ____Tuberculosis

____Ulcerative colitis ____High cholesterol ____Polyps

____Kidney disease ____Lung disease ____Hepatitis

____Endocarditis (Need antibiotics prior to procedure) ____NONE

Previous Procedure/ Surgical Information:

____EGD/Colonoscopy- Where:_____ Date:_____

____Gastric bypass/ Abdominal Surgery; Explain:_____

____Previous Surgeries (general, orthopedic, etc.) Explain: _____

Patient Signature:_____

Clinical Staff Name:_____ Signature:_____

Date:_____ Time:_____

MP Veera MD PA

864.224.8689

Patient Information Sheet

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely.
Please ask for help if you have questions about any field.
We will be unable to file insurance for incomplete forms. Thank you.

PATIENT INFORMATION

Full Name:		Social Security #:	
Date of Birth:		Name you wish to be called:	

Legal Sex: (as on your driver's license)

Gender Identity:
- ☐ Female
- ☐ Male
- ☐ Choose not to disclose
- ☐ Transgender Female (male-to-female)
- ☐ Transgender Male (female-to-male)
- ☐ Other

Sex at Birth:
- ☐ Female
- ☐ Male
- ☐ Choose not to disclose
- ☐ Unknown
- ☐ Uncertain
- ☐ Not recorded on birth certificate

Sexual Orientation:
- ☐ Straight
- ☐ Lesbian or Gay
- ☐ Choose not to disclose
- ☐ Bisexual
- ☐ Don't Know
- ☐ Something else

Mailing Address:			
City, State, Zip:		County:	
Street Address:			
City, State, Zip:		County:	
Home Phone #	Work Phone #:	Mobile #:	
Email Address:		I DON'T HAVE EMAIL NO THANKS	

Marital Status:
- ☐ Divorced
- ☐ Legally Separated
- ☐ Married
- ☐ Significant Other
- ☐ Single
- ☐ Single
- ☐ Widowed
- ☐ Other
- ☐ Unknown

Do you need an Interpreter? YES NO

Language Preference:

Written Language Preference:

Religion:

Race:
- ☐ American Indian / Alaska Native
- ☐ Asian Indian
- ☐ Asian
- ☐ Native Hawaiian / Other, Pacific Islander
- ☐ Black / African American
- ☐ White
- ☐ Unknown
- ☐ Declined

Ethnicity:
- ☐ Not Hispanic Latino/a or Spanish origin
- ☐ Colombian
- ☐ Cuban
- ☐ Guatemalan
- ☐ Honduran
- ☐ Mexican, Mexican American or Chicano/a
- ☐ Other Hispanic, Latino/a or Spanish Origin
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Declined to Answer
- ☐ Unknown

Primary Care Provider (PCP) Name:	
Emergency Contact Name and Relationship:	
Emergency Contact Phone #:	Is the Emergency Contact the Patient's Legal Gaurdian? Yes No
Employer Name:	

Employment Status:
- ☐ Full Time
- ☐ Part Time
- ☐ Self Employed
- ☐ Retired
- ☐ Disabled
- ☐ Not Employed
- ☐ Active Military Duty
- ☐ Other / Unknown

Student Status:
- ☐ Full Time
- ☐ Part Time

GUARANTOR INFORMATION

Who is financially responsible for this account? SELF EMPLOYER SPOUSE FATHER MOTHER OTHER

Primary Insurance Company:	**Secondary Insurance Company:**
Subscriber Name:	Subscriber Name:
Subscriber Social Security Number:	Subscriber Social Security Number:
Subscriber Sex:	Subscriber Sex:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Home Phone #:	Subscriber Home Phone #:
Subscriber ID #:	Subscriber ID #:
Subscriber Group #:	Subscriber Group #:

What is your preference of contact for appointment reminders? TEXT EMAIL PHONE

I authorize the following people access to my protected health or medical information (list name(s) and relationship(s) to patient):

Do you have Advanced Directives? YES NO If yes choose type: __ Health Care Power of Attorney/Living Will __ DNR

Preferred Pharmacy Name and Location:

Signature of Patient of Legal Guardian | Printed Name of Patient or Legal Guardian | Date | Time

MP VEERA MD PA

YOUR AUTHORIZATION TO COMMUNICATE FORM

As stated in the HIPAA privacy laws, this authorization form permits MP VEERA MD PA to use or disclose protected health information listed in the **Description Section** to the Entity or Person listed in the **Receiving Entity section** below for the following patient/you:

Name _____ Birth Date _____

Address _____

City/State/ Zip _____

Description of information to be given to Entity or Person.	**Receiving Entity or Person Review & list if needed carefully**
*Appointment or absentee from work information/form *Return to work or school information/form	Employer _____ School _____
*Family billing information *Financial information *Medical/List separately or mark as "ALL" _____	Spouse (Provide full name) _____ Other (Provide full name(s)) _____
*Family billing information *Financial information *Medical/List separately or mark as "ALL" _____	Parent(s) (Provide full name) _____
*Portal Log in/updates via email *Texting *Internet and social media (examples: google, facebook, instagram) viewing and communications/responses to you	Your Email _____ as updated by you Please provide updated cell number, if any _____ Internet and social media _____

Purpose

The purpose of this authorization is to meet your request for information disclosures and uses. ***(TURN PAGE TO COMPLETE FORM)***

**********TWO SIDED FORM→**

Expiration date or event: This authorization shall be in force until revoked by the patient or _____ date is the specific end date of this authorization.

Verification method or code: This practice will verify the identity of any entity or individual requesting protected health information by asking the your full name, date of birth and may request for the last four digits of your social security #

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to MP VEERA MD PA, 130 Perpetual Square Dr., Anderson, SC 29621 Attn: HIPAA Officer. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)
Description of Personal Representative's Authority (attach necessary documentation)

_____

****

Office Use Only (Employee please sign, scan and give back this original to patient):
Employee _____Date received _____

☐ **Copy given to patient by receiving employee**

MP VEERA MD PA
CONTROLLED MEDICATION
AGREEMENT
130 PERPETUAL SQ. ANDERSON, SC 29621
864.224.8689 FAX 864.222-1303

AS A GENERAL RULE WE DO NOT WRITE CONTROLLED SUBSTANCES

The purpose of this agreement is to prevent misunderstandings about certain controlled substance medications, referred to as controlled medication, and to help both you and your provider comply with the state and federal laws regarding controlled medication. Because these medications have high potential for misuse, their administration is strictly controlled by local, state and federal governments. They include such classes of drugs as narcotics (for pain management, such as OXYCONTIN, HYDROCODONE, CODEINE, and STADOL), depressants (barbiturates), anti-anxiety medications (such as XANAX and ATIVAN), sedatives (such as AMBIEN) and stimulants (such as ADDERALL, ADIPEX-P and DIDREX). Their administration is intended to relieve, but not eliminate various symptoms, often pain; and is not simply to mask an underlying problem. Overdoses of controlled medications can cause serious illness or death.

Because your provider is prescribing a controlled medication for the management of your condition, you must agree to abide by the following guidelines. Please initial beside each statement. Once read a full signature at bottom of page is required.

1. I understand that I am responsible for my controlled medication. If the medication is lost, misplaced, or stolen, or if I do not follow the prescribed directions and I use all of the medication before I am eligible for a refill, I understand it will not be replaced.
2. I will not request or accept a controlled medication from any other physician or individual while I am receiving such medication from any of MP VEERA MD PA medical providers. Not only is it illegal to do so, but it may also endanger my health. The only exception is in the event that I am admitted to a hospital and a controlled medication is prescribed for me during my stay. (Please note that hospital admission does not include visits to an emergency department or an urgent care/minor care facility.)
3. Refills of my controlled medication:
   a. Will only be given during normal office hours. Refills will not be given at night, during office holidays or on weekends.
   b. Will not be given if I use all of the medication before I am eligible for a refill. I am responsible for taking my medication according to the prescribed directions, as well as for keeping track of the remaining amount.
   c. Will only be considered with at least seventy-two (72) hours advance notice. This holds true for requests submitted prior to the weekend.
4. I understand that if I violate any of the above conditions, my controlled medication prescription and/or treatment by MP VEERA MD PA providers may be terminated immediately. If the violation involves obtaining a controlled medication from another physician or individual, I may also be reported to the prescribing physician, corresponding medical facilities, and other necessary authorities.
5. I agree to abide by my physician's judgment regarding the necessity for controlled medication and the amount/frequency of medication that is best suited to the treatment plan as it is made, as well as when to cease the use of the medication.
6. I understand that if I am pregnant or become pregnant while taking controlled medication, my child could be physically dependent on the controlled medication and withdrawal can be life-threatening for the baby.
7. I understand that unannounced drug screens may be requested, and I will be in full cooperation with the administration of these tests.
8. I agree to fill all of my controlled substance prescriptions at the same pharmacy, and to provide my pharmacy information to MP VEERA MD PA. Any change of pharmacy will be promptly reported to the office.
9. I agree not to sell, lend or in any way give my controlled medication to any other person.
10. I understand that I will attend all required follow up visits with the physician to monitor the controlled medication and that failure to do so will result in discontinuation of this treatment.
11. I understand that there is a risk of addiction from controlled medications. This means that I might become psychologically dependent on the medication, using it to change my mood, get high, or be unable to control my use of it. People with a past history of alcohol or drug abuse are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment facility.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

SIGNATURE OF WITNESS

DATE