

# AppGastro

## Contact Us

### Phone & Fax

Phone: (828) 264-0029

Fax: (828) 265-3305

### Hours

Monday - Thursday: 8:00 a.m. - 5:00 p.m.

Friday: 8:00 a.m. - 12:00 p.m.

### Location

870 State Farm Road, Suite 102  
Boone, NC 28607

436 Hospital Drive, Suite 110  
Linville, NC 28646

Thank you for choosing AppGastro as your healthcare provider. We look forward to seeing you at your appointment.

This new patient information packet includes directions to our office and contact information for your records. Also enclosed is the paperwork that you will need for your upcoming appointment. Please complete the paperwork enclosed and bring it to your appointment. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available online at [unhealthappalachian.org](http://unhealthappalachian.org).

Established in 1997, AppGastro specializes in the prevention, diagnosis and treatment of diseases that affect the digestive tract. Patients are often referred to AppGastro if they need to schedule a colonoscopy or if they suffer from acid reflux, indigestion, nausea, bloating, gallbladder disorders or abdominal pain.

At AppGastro, we believe that each patient and provider become a team for treating an individual's digestive problems. Our gastroenterology providers spend most of their time listening in order to understand your concerns and responding with the best treatment options for you. With the help of our professional staff, they also follow up to make sure that problems are resolved and your health improves.

AppGastro has achieved accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC). Accreditation distinguishes our practice from many other outpatient facilities by providing the highest quality of care to its patients as determined by an independent, external process of evaluation.

## New Patient Checklist

*For your first appointment, please arrive 15 minutes early and bring the following:*

- Insurance Card
- Pharmacy Information
- Medical Records
- Payment
- Current Medications/Prescription Bottles
- Questions for doctor
- Photo ID
- Completed forms from this packet

\_\_\_\_\_ has an appointment with

\_\_\_\_\_  Mon.  Tues.  Wed.  Thurs.  Fri.

\_\_\_\_\_ date \_\_\_\_\_ a.m./p.m.

Boone, NC  Linville, NC

To reschedule your appointment, please call (828) 264-0029.

**UNC**  
HEALTH®  
Appalachian

[unhealthappalachian.org](http://unhealthappalachian.org)

HDF9216 02/19/26



Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Family Medical History-AppGastro

- I have no knowledge of my family history
- I have no family history of  chronic liver disease, hepatitis or cirrhosis,  colorectal cancer,  colorectal polyps,  inflammatory bowel disease.
- I have family history of the following diagnoses (check only if affected by the listed family members)

	Mother	Father	Sister	Brother	Daughter	Son	Maternal					Paternal				
							Grand mother	Grand father	Aunt	Uncle	First Cousin	Grand mother	Grand father	Aunt	Uncle	First Cousin
Barrett's Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease/Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Familial Polyposis Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

**Patient Registration Form (ARMA)**

**Form #11332**

**Patient Name:** First \_\_\_\_\_ M/I \_\_\_\_\_ Last \_\_\_\_\_

**Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Gender:**  Male  Female **Social Security #:** \_\_\_-\_\_\_-\_\_\_

**Marital Status:**  Married  Single  Divorced  Separated  Widowed  Life Partner

**Mailing Address:** Street- \_\_\_\_\_

City- \_\_\_\_\_ State- \_\_\_\_\_ Zip Code- \_\_\_\_\_

**Primary Phone #:** \_\_\_\_\_  Cell  Home

**Secondary Phone #:** \_\_\_\_\_  Cell  Home

**Work Phone #:** \_\_\_\_\_ **Employer/Occupation:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_ **Ph #:** \_\_\_\_\_

I consent to Appalachian Regional Medical Associates (“ARMA”) or its representatives:  calling my phone and leaving a message  texting me (message and data rates may apply)  e-mailing me about balances due, financial assistance, appointments, pre-registration, lab results, and other healthcare information. Methods of contact may include pre-recorded voice messages and the use of automatic dialing services.

**What is your ethnicity?**  Hispanic or Latino  Not Hispanic or Latino

**Select one or more races to indicate what you consider yourself to be:**  Asian  White

American Indian or Alaskan Native  Black or African American

Native Hawaiian or other Pacific Islander  Other: \_\_\_\_\_

**Preferred language?**  English  Spanish  Other: \_\_\_\_\_

**How did you hear about us?**

Billboards  Doctor  Friends/Family  Magazine  Newspaper  Social Media  Radio  TV

ARHS Website  Other \_\_\_\_\_

**If patient is a minor please print Guardian Name:**

First: \_\_\_\_\_ M/I: \_\_\_\_\_ Last: \_\_\_\_\_

If patient has a guarantor (someone else responsible for the bill) please provide information below:

**Patient’s relationship to Guarantor:** \_\_\_\_\_

**Guarantor’s Name:** First: \_\_\_\_\_ M/I: \_\_\_\_\_ Last: \_\_\_\_\_

**Mailing Address:** Street- \_\_\_\_\_

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

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_-\_\_\_-\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Signature of Patient/ Legal Representative ▶		Date: Time:
Name of Patient/ Legal Representative (Please Print) ▶	Relationship of Legal Representative ▶	

Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**Limited Release of Information to Family/Friends for Physician Clinics**  
**HIM# 1315s**

**I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below.** These individuals will only be given information about me that is related to their involvement in my care or payment for my care.<sup>1</sup> I understand that I am not required to complete this form in order to obtain health care.

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

Relationship: \_\_\_\_\_ Talk to this person about (*check each box that applies*):

Any non-sensitive<sup>2</sup> information regarding my health care or payment for my health care.

**OR**

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

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

Relationship: \_\_\_\_\_ Talk to this person about (*check each box that applies*):

Any non-sensitive<sup>2</sup> information regarding my health care or payment for my health care.

**OR**

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

**If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.**

\_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): \_\_\_\_\_

<sup>1</sup> This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

**This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.**

<sup>2</sup> Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**





## Patient Request for Access to Protected Health Information (PHI)

HIM# 1409s

<i>Patient's Name (print)</i>	<i>Phone Number</i>	<i>Date of Birth</i>
<i>Patient's Address</i>		<i>Medical Record #</i>

**INFORMATION THAT CAN BE RELEASED:** If specific dates only, list dates: \_\_\_\_\_

**Type of Records Being Requested** (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> All My Medical Records                | <input type="checkbox"/> Emergency Dept. Notes      |
| <input type="checkbox"/> Urgent Care Center Notes              | <input type="checkbox"/> History and Physical       |
| <input type="checkbox"/> Operative/Procedure Notes             | <input type="checkbox"/> Provider Orders            |
| <input type="checkbox"/> Discharge Summaries                   | <input type="checkbox"/> Consultations              |
| <input type="checkbox"/> Laboratory Reports                    | <input type="checkbox"/> Progress Notes (inpatient) |
| <input type="checkbox"/> Radiology Reports                     | <input type="checkbox"/> Patient Billing Records    |
| <input type="checkbox"/> Radiology Images/CD (Imaging Support) | <input type="checkbox"/> Nursing Notes              |
| <input type="checkbox"/> Clinic Notes (outpatient)             |   |
| <input type="checkbox"/> Other (describe in detail): _____     |   |

**Person/Company that you wish to receive your records**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Fax (if applicable): \_\_\_\_\_

**Please check if you wish to authorize the release of sensitive medical information:**  Mental Health/Psychiatric Treatment  Genetic Testing Information  Alcohol or Substance Abuse Treatment  Sexually Transmitted Infection/HIV/AIDS Treatment(s) or Test(s)

**Format Requested / Delivery Method**

- Mail paper records to address listed above  
 Review or pick up paper records in Health Information Management (HIM) Department  
 Verbal release to person identified above  
 Fax to number listed above (Health care providers only; no personal faxes)  
 Other: (describe) \_\_\_\_\_

**Fees:** A reasonable cost-based fee may be charged for copies of records being requested. Patients may request a cost estimate from HIM in advance.

- Receive electronically via email\*  Encrypted  Unencrypted  
 USB\* Data provided in unencrypted electronic formats poses inherent risks of potential interception or compromise.  
 \*If I choose to receive my medical information via an unencrypted electronic format, I accept all associated risks.  
 Release to web portal via MyUNC Chart in electronic format. (Access will only be available for 30 days; you may print and/or save a copy for personal use) \*\*This option is only available for records that were created in Epic.

**If you do not have a MyUNC Chart you may sign up for an account here:**  
<https://myuncchart.org/mychart/>

**Expiration:** Unless previously revoked, this Authorization will expire on the following date, event or condition: (list date, event or condition) \_\_\_\_\_ . If I fail to specify an expiration date or event or condition, this Authorization shall remain in effect for **one (1) year** from the date I sign it. **Please note that records created after the date of signature on this form but prior to the expiration date will be released pursuant to this form unless otherwise indicated above.**

<i>Signature of Patient</i>	<i>Date</i>	<i>Time</i>
<i>OR Signature of Authorized Representative</i>	<i>Date</i>	<i>Time</i>
<i>Printed Name of Authorized Representative</i>	<i>Phone Number of Authorized Representative</i>	

*Explain Representative's authority to act on behalf of the Patient:*



## Patient Request for Access to Protected Health Information (PHI)

HIM# 1409s

Please send your completed Request for Patient Access to Protected Health Information (PHI) Form by fax, mail or email to the appropriate entity at the contact information listed below.

**NOTE: If only requesting radiology film, please send request to the appropriate radiology department at the contact information listed below.**

<p>UNC Health</p>	<p>UNC Health Information Management            Attn: Release of Information            500 Eastowne Drive, Chapel Hill, NC 27514            (fax) 984-974-0471; (phone) 984-974-3226            Email: <a href="mailto:relmedinfo@unchealth.unc.edu">relmedinfo@unchealth.unc.edu</a></p> <p>For radiology images <u>only</u>:            UNC Hospitals Radiology Department            (fax) 984-974-8814; (phone) 984-974-9362            Email: <a href="mailto:FILMmail@unchealth.unc.edu">FILMmail@unchealth.unc.edu</a></p>
<p>UNC Health Rex</p>	<p>UNC Health Rex Health Information Management            Attn: Release of Information            4420 Lake Boone Trail, Raleigh, NC 27607            1st Floor, Main Hospital            (fax) 919-784-3343; (phone) 919-784-3158</p> <p>For radiology images <u>only</u>:            Rex Healthcare / Rex Hospital Radiology Department            (fax) 919-784-3497; (phone) 919-784-3023</p>
<p>UNC Health Caldwell</p>	<p>UNC Health Caldwell Health Information Management            Attn: Release of Information            321 Mulberry St SW, Lenoir, NC 28645            (fax) 828-757-5169 (phone) 828-757-5100</p> <p>For radiology images <u>only</u>:            Caldwell Memorial Hospital Radiology Department            (fax) 828-757-5206; (phone) 828-757-5204</p>
<p>UNC Health Chatham</p>	<p>UNC Health Chatham Health Information Management            Attn: Release of Information            475 Progress Blvd. Siler City, NC 27344            (fax) 919-799-4801; (phone) 919-799-4804</p> <p>For radiology images <u>only</u>:            Chatham Hospital Radiology Department            (fax) 919-799-4601; (phone) 919-799-4600</p>
<p>UNC Physicians Network</p>	<p>Return directly to UNC Physicians Network Clinic</p>
<p>UNC Health Johnston</p>	<p>UNC Health Johnston Health Information Management            Attn: Release of Information            PO Box 1376, Smithfield, NC 27577            (fax) 919-934-9266; (phone) 919-938-7705</p>



## Patient Request for Access to Protected Health Information (PHI)

HIM# 1409s

	<p>For radiology images <u>only</u>:</p> <ul style="list-style-type: none"> <li>• <i>Smithfield Hospital Location</i> UNC Health Johnston Radiology Department 509 N. Brightleaf Blvd., Smithfield, NC 27577 (fax) 919-989-9795; (phone) 919-938-7190</li> <li>• <i>Clayton Hospital Location</i> UNC Health Johnston Radiology Department 2138 NC Highway 42W, Clayton, NC 27520 (fax) 919-585-8462; (phone) 919-585-8450</li> </ul>
UNC Health Pardee	<p>UNC Health Pardee Health Information Management Attn: Release of Information 800 North Justice Street, Hendersonville, NC 28791 (fax) 828-696-1097; (phone) 828-696-1094</p> <p>For radiology images <u>only</u>: UNC Health Pardee, Attn: Radiology 800 North Justice Street, Hendersonville, NC 28791 (fax) 828-696-1076; (phone) 828-969-1040</p>
UNC Health Nash	<p>UNC Health Nash Health Information Management 2460 Curtis Ellis Drive, Rocky Mount, NC 27804 (fax) 252-962-8291; (phone) 252-962-8130</p>
UNC Health Lenoir	<p>UNC Health Lenoir Health Information Services Attn: Release of Information 100 Airport Rd, PO Box 1678, Kinston, NC 28503-1678 (fax) 252-522-7099; (phone) 252-522-7185</p>
UNC Health Wayne	<p>UNC Health Wayne Health Information Management 2700 Wayne Memorial Drive, Goldsboro, NC 27534 (fax) 919-587-2975; (phone) 919-731-6117</p> <p>For radiology images <u>only</u>: UNC Health Wayne, Radiology Department 2700 Wayne Memorial Drive, Goldsboro, NC 27534 (phone): 919-731-6013</p>
UNC Health Rockingham	<p>UNC Health Rockingham Health Information Management 117 E Kings Hwy, Eden, NC 27288 (fax) 336-623-6902; (phone) 336-627-6194</p> <p>For radiology images <u>only</u>: UNC Health Rockingham Diagnostic Imaging 117 E Kings Hwy, Eden, NC 27288 (fax) 336-623-1345; (phone) 336-623-9711 x1712262</p>
UNC Health Blue Ridge	<p>UNC Health Blue Ridge Health Information Management 2201 S. Sterling Street, Morganton NC, 28655 (fax): 828-580-6859 (phone): 828-580-6938</p>
UNC Health Southeastern	<p>UNC Health Southeastern Health Information Management 300 W 27th Street, Lumberton, NC 28358 (fax): 910-671-5349 (phone): 910-671-5539</p>



## Patient Request for Access to Protected Health Information (PHI)

HIM# 1409s

	For radiology images <u>only</u> : UNC Health Southeastern Medical Imaging Department (fax): 910-671-5209 (phone): 910-671-5054
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Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

**Wellness/Preventative Visit Information**  
**Form #11057**

Dear Patient,

You have a Wellness/Preventative Care Visit scheduled today. Your health care provider believes spending time talking about staying healthy is worth the effort. We know protecting your health is important to you and thank you for choosing Appalachian Regional Medical Associates (ARMA) as your health care provider.



We want you to know what may happen with your insurance benefits for today’s visit. Many insurance health plans will pay 100% for wellness/prevention visits, which may or may not include lab or imaging services. These visits only cover ways to improve or maintain healthy habits. They often do not cover talking to your health care provider about other items, such as current health problems.

We know that many people want to talk to their health care provider about all of their health concerns at their wellness visit as this can save time. If your visit with your health care provider today includes talking about current or new health problems, your insurance company may not pay 100%. They may ask you to pay some of the cost. This may be a co-pay, deductible, or a part of the charge.

The health care providers at ARMA work hard to give you the best health care. Our goal is to help you stay healthy and keep you informed about your health.

Each patient should check his/her own insurance coverage to help them know what will be paid for during a wellness/prevention visit when also talking about current or new health problems. Your health care provider must file your insurance claim based upon everything that was done at your visit.

**I have read and understand the above information to my satisfaction. I understand my insurance plan may ask that I pay a portion of today’s visit.**

	Patient Name (Print):	Date: Time:
	Patient/Guardian (note relationship) Signature:	Date: Time:

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

**Patient Interview Form-AppGastro**  
**Form #11632**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Pharmacy \_\_\_\_\_  
 Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care \_\_\_\_\_  
 Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**Allergies**

- I have no known food allergies
- I have the following **food** allergies -
- Shellfish  Eggs  Other \_\_\_\_\_
- I have the following **miscellaneous** allergies -
- Latex  Environmental \_\_\_\_\_  Materials \_\_\_\_\_
- Other \_\_\_\_\_

- I have no known drug allergies
- I have the following **drug** allergies -
- Penicillins  Sulfa (Sulfonamide Antibiotics)
- IV Dye, Iodine Containing Contrast Media
- Other \_\_\_\_\_

**Immunizations and Last Date Received**

- Flu \_\_\_\_\_  Hepatitis A \_\_\_\_\_  Hepatitis B \_\_\_\_\_
- Shingles \_\_\_\_\_  TB Test \_\_\_\_\_  COVID19 \_\_\_\_\_
- Pneumonia (PPV23) \_\_\_\_\_

**Diagnostic Studies and Date Performed**

- I have had no diagnostic studies performed
- Colonoscopy \_\_\_\_\_  Upper Endoscopy (EGD) \_\_\_\_\_  ERCP \_\_\_\_\_
- Capsule Endoscopy \_\_\_\_\_  Small Bowel FT \_\_\_\_\_  Gastric Emptying \_\_\_\_\_
- Flexible Sigmoidoscopy \_\_\_\_\_  PH Monitoring \_\_\_\_\_  Sitz Marker Test \_\_\_\_\_
- Swallowing Study \_\_\_\_\_  Skin Check \_\_\_\_\_  DEXA (Bone Density) \_\_\_\_\_
- Pap-Smear \_\_\_\_\_  Cologuard \_\_\_\_\_

**Past or Present Medical Conditions and Date of Diagnosis**

- I have no past or present medical conditions
- Reflux \_\_\_\_\_  Carpal Tunnel \_\_\_\_\_  Constipation \_\_\_\_\_
- Asthma \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  High cholesterol \_\_\_\_\_
- Blood Transfusion \_\_\_\_\_  Pulmonary Embolus \_\_\_\_\_  Sleep Apnea \_\_\_\_\_
- CPAP Used \_\_\_\_\_  On Oxygen \_\_\_\_\_  Heart Valve Replaced \_\_\_\_\_
- Visual Impairment \_\_\_\_\_  Hearing Impairment \_\_\_\_\_  Language Barrier \_\_\_\_\_
- Diabetes Type 1 \_\_\_\_\_  Diabetes Mellitus Type 2 \_\_\_\_\_  Coronary Artery Disease \_\_\_\_\_
- COPD \_\_\_\_\_  Depression \_\_\_\_\_  Anxiety \_\_\_\_\_
- Allergic Rhinitis \_\_\_\_\_  Previous Anesthesia Related Complications \_\_\_\_\_
- C. Difficile \_\_\_\_\_  Flu \_\_\_\_\_  Herpes Zoster \_\_\_\_\_
- MRSA \_\_\_\_\_  Recently Screened for HIV \_\_\_\_\_  Congestive Heart Failure \_\_\_\_\_
- Heart Attack \_\_\_\_\_  Angina \_\_\_\_\_  Sickle Cell Anemia \_\_\_\_\_
- Currently pregnant or breastfeeding \_\_\_\_\_  Malignant Hyperthermia \_\_\_\_\_  Hypothyroidism \_\_\_\_\_
- Cancer of Head and/or Neck \_\_\_\_\_  Radiation Treatment to Head and/or Neck \_\_\_\_\_
- History of Difficult Intubation \_\_\_\_\_  Other \_\_\_\_\_

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

**Previous Procedures and Date of Service**

- I have no past or present medical conditions
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Appendix removed _____             | <input type="checkbox"/> Gallbladder removed _____             | <input type="checkbox"/> Colon Resection _____      |
| <input type="checkbox"/> Pacemaker _____                    | <input type="checkbox"/> Hip Joint Replaced _____              | <input type="checkbox"/> Knee Joint Replaced _____  |
| <input type="checkbox"/> Shoulder Joint Replaced _____      | <input type="checkbox"/> Spinal Fusion _____                   | <input type="checkbox"/> Heart Valve Replaced _____ |
| <input type="checkbox"/> Tubal Ligation _____               | <input type="checkbox"/> Coronary Artery Stent Placement _____ |   |
| <input type="checkbox"/> Tonsillectomy/ Adenoidectomy _____ | <input type="checkbox"/> Cataract Surgery _____                | <input type="checkbox"/> Hernia Surgery _____       |
| <input type="checkbox"/> Total Vaginal Hysterectomy _____   | <input type="checkbox"/> Total Abdominal Hysterectomy _____    |   |
| <input type="checkbox"/> Head and/or Neck Surgery _____     | <input type="checkbox"/> Coronary Artery Bypass Grafting _____ |   |
| <input type="checkbox"/> Other _____                        |  |   |

**Social History**

**Occupation** \_\_\_\_\_

**Alcohol - Total number of cans/glasses**

- I do not drink alcohol
- I drink the following alcoholic beverages (list the frequency per week)
- |                                     |                                     |                                       |   |
|-------------------------------------|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Beer _____ | <input type="checkbox"/> Wine _____ | <input type="checkbox"/> Liquor _____ | <input type="checkbox"/> Recovering Alcoholic |
|-------------------------------------|-------------------------------------|---------------------------------------|---|

**Caffeine - Total number of cups/glasses**

- I do not consume caffeine
- I consume the following caffeinated items (list the frequency per week)
- |                                       |                                    |                                     |  |  |
|---------------------------------------|------------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> Coffee _____ | <input type="checkbox"/> Tea _____ | <input type="checkbox"/> Soda _____ | <input type="checkbox"/> Energy Drinks _____ | <input type="checkbox"/> Chocolate _____ |
|---------------------------------------|------------------------------------|-------------------------------------|--|--|

**Tobacco**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Current Every Day Smoker       | <input type="checkbox"/> Current Some Day Smoker | <input type="checkbox"/> Former Smoker        | <input type="checkbox"/> Never Smoker           |
| <input type="checkbox"/> Smoker, current status unknown | <input type="checkbox"/> Light Tobacco Smoker    | <input type="checkbox"/> Heavy Tobacco Smoker | <input type="checkbox"/> Unknown If Ever Smoked |
| <input type="checkbox"/> Cigarettes                     | <input type="checkbox"/> Chewing Tobacco         | <input type="checkbox"/> Cigars               | <input type="checkbox"/> Other                  |

**Drug Use**

- I do not use drugs
- I use or have used the following drugs (list the frequency)
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> IV Drugs _____ | <input type="checkbox"/> Marijuana _____ | <input type="checkbox"/> Methamphetamine _____ |
| <input type="checkbox"/> Other _____    |  |  |

I, \_\_\_\_\_, **certify that the above information is correct to the best of my knowledge.**  
Print Patient Name

Signature of Patient/ Legal Representative ▶		Date: Time:
Name of Patient/ Legal Representative <i>(Please Print)</i> ▶	Relationship of Legal Representative ▶	

## GENERAL CONSENT FOR TREATMENT (PAGE 1 of 2)

HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health) is an integrated health system made up of various entities as reflected at [www.unchealthcare.org/documentapplicability](http://www.unchealthcare.org/documentapplicability) (each referred to in this form as a “UNC Health affiliate” or collectively as “UNC Health affiliates”). **This consent will be effective for 1 year after the date I sign it at any UNC Health affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

### Consent for Treatment/Care

I consent to treatment and care by UNC Health affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health affiliates (including but not limited to physicians and providers in the specialties of emergency medicine, anesthesia, surgery, pathology, psychiatry, obstetrics and gynecology, radiology, oncology, cardiology, neurology, pediatrics and internal medicine) but are authorized by UNC Health affiliates to provide treatment and care to me as a patient of the UNC Health affiliate, and who provide services to the UNC Health affiliates’ patients in accordance with their professional judgment (collectively, “Independent Providers”). I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care that I have received from UNC Health affiliates. I understand that my care team at UNC Health affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

### Consent for Use and Release of Information

I give permission to UNC Health affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services as permitted by law. For more detailed information about the way my information may be used or released, I can read UNC Health’s *Notice of Privacy Practices*.

I give permission to UNC Health affiliates and their employees, agents, and contractors to take photographs or make videos of me for permissible treatment, payment, health care operations, education and for research purposes where either I have given consent or an Institutional Review Board has approved as long as such recordings are consistent with policies and laws that protect my rights.

### Consent for Use Within UNC Health

I further give permission to UNC Health affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

### Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, guardian, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health affiliates. I designate UNC Health as my authorized representative with respect to any health or liability insurance policy or any group health plan, fund or program applicable to me, and I authorize UNC Health to exercise on my behalf any grievance, claim or appeal rights, including external review rights, I may have under any such health or liability insurance policy or group health plan, fund or program.

### Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health affiliate on my behalf. I authorize UNC Health affiliates to bill directly and assign the right to



\* S D C O N A U T \*

all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health affiliate.

**Social Security Number**

I have given my social security number voluntarily. UNC Health affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

**Wireless Telephone Number and Electronic Mail**

UNC Health affiliates, Independent Providers (as defined above), and/or any of their respective agents, representatives, or business associates (including their billing service providers or debt collectors), may contact me by electronic mail or telephone (including phone calls, prerecorded messages using automated technology, or text messages) at any electronic mail address or number contained in my UNC Health affiliate's or my Independent Provider's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, requesting information about patient satisfaction, servicing my account, and/or collecting amounts due. I also understand that UNC physician researchers or members of their research team may also contact me via phone or electronic mail to determine my interest in participating in human subjects research. I consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology from UNC Health Care affiliates, Independent Providers, and/or any of their respective agents, representatives or business associates, including their billing service providers or debt collectors. I understand that consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology is not required to receive health care services. I understand that if I wish to revoke consent to receive communications from UNC Health affiliates via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by calling UNC Health Customer Service at (888) 996-2767. If I wish to revoke consent to receive communications from an Independent Provider via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by contacting the Independent Provider directly.

**Personal Property**

Unless I am a resident of a skilled nursing facility, I understand that UNC Health affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health affiliates from all liability for the loss or theft of, or damage to, such belongings.

**I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.**

**I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, BEEN OFFERED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.**

\_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_  
PATIENT SIGNATURE (or Authorized Representative)

\_\_\_\_\_  
PRINTED NAME

RELATIONSHIP, if not patient: \_\_\_\_\_

**GUARANTOR OF PAYMENT:** This line may be signed by someone who wishes to agree to be responsible for payment *other than*: 1) the patient, 2) the patient's spouse, or 3) a minor patient's parent.

By signing as guarantor below, I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay.**

\_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_  
GUARANTOR OF PAYMENT SIGNATURE

\_\_\_\_\_  
PRINTED NAME



**Who will bill me and what is the estimated out of pocket expense?**

*Watauga Medical Center – Patient Accounts, 828-262-4111*

Physician Professional Fee

Pathology Service - Processing specimens to produce slides for the pathologist to read

WMC or AppGastro Facility Fee

*Pathologist Diagnostic Services, P.L.L.C- Toll Free 1-844-210-9947*

Pathology Service - Diagnostic interpretation of the slides processed at WMC

**Colonoscopy CPT (Procedure Code) – 45378**

*Preventive Screening Colonoscopy* – Patient is asymptomatic (no gastrointestinal symptoms either past or present), age 50 or older, has no personal or family history of GI disease, colon polyps and/or cancer. The patient has not undergone a colonoscopy within the last 10 years. Generally paid at 100% by most insurance companies.

*Surveillance Colonoscopy* – Patient has past and/or present gastrointestinal symptoms, polyps, GI disease or anemia OR Patient is asymptomatic (no present GI symptoms), but has a personal history of GI disease, personal and/or family history of colon polyps and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g, every 2-5 years). Generally applied to a deductible and/or coinsurance by most insurance companies.

*Diagnostic Colonoscopy* – Patient has past and/or present gastrointestinal symptoms (diarrhea, constipation, abdominal pain, etc.), polyps, GI disease or anemia. Generally applied to a deductible and/or coinsurance by most insurance companies.

*If a polyp(s) is removed during a screening or surveillance colonoscopy, the insurance company may consider the procedure and/or pathology charges to be diagnostic.*

**Upper Endoscopy - EGD CPT (Procedure Code) – 43239**

All EGD procedures are processed as diagnostic.

**Flexible Sigmoidoscopy - Flex Sig CPT (Procedure Code) – 45330**

All Flex Sig procedures are processed as diagnostic.

**How will I know what I will owe?**

**Insured Patients**

Call your insurance carrier and verify the benefits and coverage by asking the following questions. The code to give the insurance representative for a colonoscopy is **45378**, for an EGD **43239** and for a Flex Sig **45330**. **This code may change when the claim is submitted to the insurance company depending on the complexity of the procedure.** You will also need to give the insurance representative your colonoscopy procedure type as indicated above (Preventive, Surveillance or Diagnostic). All Upper Endoscopy and Flexible Sigmoidoscopy procedures are diagnostic.

Is the procedure covered under my policy (Colonoscopy, EGD, Flex Sig)?  Yes  No

Will the colonoscopy be processed as Preventive, Surveillance or Diagnostic and what are my benefits for that service? (Results may vary based on how the insurance company recognizes the reason for your procedure).

Deductible: \_\_\_\_\_ Coinsurance: \_\_\_\_\_ Copay: \_\_\_\_\_

Is the facility in network?  Yes  No

Is the physician in network?  Yes  No

Do I have Preventive/Wellness/Routine Colonoscopy Benefits?  Yes  No

Are there age and/or frequency limits for my colonoscopy? (e.g., one every 10 years over the age of 45, one every two years for a personal history of polyps beginning at age 40, etc.)  Yes  No

If so: \_\_\_\_\_

Deductible: \_\_\_\_\_ Coinsurance: \_\_\_\_\_ Copay: \_\_\_\_\_

If the physician removes a polyp, will this change my out of pocket responsibility? (A biopsy or polyp removal may change a screening benefit to a medical necessity benefit which equals more out of pocket expenses. Carriers vary on this policy.)

Yes  No

Representative's Name \_\_\_\_\_ Call Reference \_\_\_\_\_ Date \_\_\_\_\_

### **Uninsured patients**

You will be required to pay a pre-payment of \$550 at the time of your procedure. Your final billing statement will include a 40% discount.

The Average Fees vary depending on length of procedure, number of biopsies and complexity of the procedure.

You will receive a separate billing statement from Pathologist Diagnostic Services (PDS), PLLC and Watauga Medical Center (WMC) for all pathology charges.

To obtain estimated pathology charges from PDS, call toll free 844-210-9947. Let them know you are a patient of Appalachian Regional Healthcare System. They will honor our Self-Pay Discounts.

To obtain estimated pathology charges from WMC, call 828-262-4111.

For information concerning the WMC Financial Assistance Program, call 828-262-4110 or send an email to [patquestion@apprhs.org](mailto:patquestion@apprhs.org).

If you are in need of setting up a payment plan, ask our Check Out Receptionist for information about AccessOne.

If you have applied for Medicaid, you will be scheduled at Watauga Medical Center. Please contact us as soon as the Medicaid is approved. We will need your Medicaid ID Number in order to process your claims.

### **Frequently Asked Questions**

**Can the physician change, add, or delete my diagnosis so that my procedure can be considered a preventive/wellness/routine screening? NO! The patient encounter is documented as a medical record from information you have provided. It is a binding legal document that cannot be changed to facilitate better insurance coverage.**

**What if my insurance company tells me that the physician can change, add or delete a CPT or diagnosis code? Often the representative will tell the patient that if the "doctor codes this as a screening; it will be covered differently". A member services representative should never suggest a physician alter a medical record for billing purposes.**



## Cost Estimation Worksheet What will I owe for lab testing?

### **Who will bill me?**

You may receive a bill from Watauga Medical Center, Cannon Memorial Hospital, or Appalachian Regional Medical Associates. Contact the Patient Accounts Department at 828-262-4111 or [patquestion@apprhs.org](mailto:patquestion@apprhs.org) with questions.

### **Is my test a Screening Test or Diagnostic Test?**

- Screening Test* – Patient does not have symptoms, and the provider is testing to see IF the patient has a medical issue. Generally paid at 100% by most insurance companies, *if included in their list of screening tests.*
- Diagnostic Test* – Patient has past and/or present symptoms. Provider KNOWS patient has a specific condition and needs to order follow-up testing. Generally applied to a deductible and/or coinsurance by most insurance companies.

### **How will I know what I will owe?**

Call your insurance carrier and ask the following questions to see what coverage they offer. The code to give the insurance representative for your testing will be on the lab order you receive from your provider.

1. Do I have Screening and Diagnostic Lab Testing Benefits?     Yes     No
2. Is the test covered under my policy?     Yes     No
3. What is the difference in coverage if the testing is processed as Screening vs. Diagnostic? (Results may vary based on how the insurance company recognizes the reason for your test)
  - Screening: What is the Deductible? \_\_\_\_\_ Coinsurance? \_\_\_\_\_ Copay? \_\_\_\_\_
  - Diagnostic: What is the Deductible? \_\_\_\_\_ Coinsurance? \_\_\_\_\_ Copay? \_\_\_\_\_
4. Is the facility in network?     Yes     No
5. Is the healthcare provider in network?     Yes     No
6. Are there age and/or frequency limits for my lab testing?     Yes     No

If so: \_\_\_\_\_

Deductible: \_\_\_\_\_ Coinsurance: \_\_\_\_\_ Copay: \_\_\_\_\_

Representative's Name \_\_\_\_\_ Call Reference \_\_\_\_\_ Date \_\_\_\_\_

### **Frequently Asked Questions**

**Can the physician change, add, or delete my diagnosis so that my testing can be considered a screening?**  
***NO!*** The patient encounter is documented as a medical record from information you have provided. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

**What if my insurance company tells me that the physician can change, add or delete a CPT or diagnosis code?** Often the representative will tell the patient that if the “doctor codes this as a screening, it will be covered differently.” A member services representative should never suggest a physician fraudulently alter a medical record for billing purposes.

**Please allow 5-7 days for your results.**

**If results are normal, you will receive a letter in the mail or in MyChart.**

**If results are abnormal, you will receive a phone call.**