GASTROENTEROLOGY
MEDICAL CLINIC
*Compassionate and Personalized Care*

8105 Saratoga Way, Suite 210
El Dorado Hills, CA 95762
916-983-4444
**www.gastromedclinic.com**

# WELCOME LETTER

DATE: _____

Dear_____:

Your first visit has been scheduled on _____, at

_____, with Doctor _____. This visit will be for consultation only. No procedure will be done at this visit. No special diet is necessary.

In order to make your first visit as meaningful and productive as possible, please fill out the enclosed "PATIENT HISTORY" packet, making sure you sign the appropriate consents and releases. Bring the completed forms with you at the time of your appointment.

For office visits, procedures and hospitalizations, your primary and supplemental insurances will be billed for you. Therefore, we request you bring your medical insurance cards and, if required, your insurance forms. Any co-pays required by your insurance will be expected at the time of your visit.

*PLEASE NOTE:* It is very important that you bring with you or have your attending physician send us copies of any current lab tests, X-ray reports or any other pertinent information.

If you have any difficulty in complying with any of the above items, our office staff will assist you in any way possible.

We look forward to meeting you in the near future.

Cordially,

GASTROENTEROLOGY MEDICAL CLINIC STAFF

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PRIMARY CARE PROVIDER: _____ REFERRING PROVIDER: _____

## PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: ____ / ____ / _____ GENDER: ❑ MALE ❑ FEMALE ❑ OTHER SSN: XXX-XX- _____

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

(Please check the box to indicate your preferred means of communication)

❑ HOME PHONE: _____ ❑ WORK PHONE: _____

❑ CELL PHONE: _____ ❑ EMAIL: _____

EMPLOYER: _____ MARITAL STATUS: _____

RACE: ❑ AMERICAN INDIAN/ALASKA NATIVE ❑ BLACK/AFRICAN AMERICAN ❑ WHITE/CAUCASIAN ❑ ASIAN
❑ HAWAIIAN/PACIFIC ISLANDER ❑ OTHER ❑ UNKNOWN ❑ DECLINED

LANGUAGE: _____ ❑ INTERPRETER NEEDED: _____

SPOUSE'S NAME: _____ SPOUSE'S DATE OF BIRTH: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ OTHER PHONE: _____

## INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DOB: _____ EFFECTIVE DATE: _____

INSURANCE ID#: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DOB: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

OTHER INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DOB: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

## PROOF OF INSURANCE / ASSIGNMENT & RELEASE OF BENEFITS

Patients are required to show both proof of insurance and a government-issued photo ID at their initial and subsequent visits. The patient (or parent/legal guardian) is responsible for informing our office of any changes in your insurance coverage since your last visit. Please ensure that notification is made no later than 24 hours prior to your appointment to avoid having to reschedule.

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **Gastroenterology Medical Clinic.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

SIGNED: _____ DATE: _____

RELEASE OF INFORMATION: I hereby authorize Gastroenterology Medical Clinic to release information to my insurance company with regard to all treatment as is necessary to obtain payment for their services and to review activity related to the provider's participation with my insurance plan. I assign all benefits, to which the patient or insured is entitled for my treatment and medical services provided to me, to be paid directly to Gastroenterology Medical Clinic. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge I am bound to pay for services rendered, including all costs of collection and reasonable legal fees should collection become necessary. I have read and understand this Financial Policy, and by signing, I am in agreement and accept all terms and conditions described above.

_____ _____
Patient/Guardian Signature Date

# PRACTICE POLICIES

## FINANCIAL RESPONSIBILITY AGREEMENT

Initials _____

Thank you for choosing Gastroenterology Medical Clinic as your gastrointestinal healthcare provider. Our goals are to provide you with excellent gastroenterology care, minimize your out of pocket expenses, and make paying your balance as easy as possible. Our financial department is dedicated to informing you, to the best of our ability, of your estimated portion of the charges for your care and assisting you with any billing questions you may have.

INSURANCE: For the convenience of the patient, we will file medical claims with insurance plans with which we have an agreement as long as valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of his or her insurance claim. The patient is to be considered self-pay until this information is provided to us.

The patient is responsible for notifying our office of any insurance changes prior to scheduled appointments. Insurance policies are an agreement between the patient and his or her insurance company. All account balances are the responsibility of the patient. Payment is due from the patient upon receipt of the first statement from our office.

The patient is expected to know his or her insurance benefits to include deductible and co-payments. Co-payments are to be paid at the time of service. If the patient does not have medical insurance, or if Gastroenterology Medical Clinic providers are not participating with his or her insurance carrier, all charges incurred during treatment are due and payable at the time of service.

ALL CHECKS RETURNED FOR NON-SUFFICIENT FUNDS WILL BE ASSESSED A $25.00 CHARGE.

## MEDICARE ASSIGNMENT AND AUTHORIZATION TO SUBMIT CLAIMS

Initials _____

I request that payment of authorized MEDICARE benefits be made on my behalf to Gastroenterology Medical Clinic for any services furnished to me by any physicians associated with Gastroenterology Medical Clinic.

I understand that my signature requests that payment be made directly to a physician associate of Gastroenterology Medical Clinic and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form (the Medicare insurance billing form) or elsewhere on other approved claim forms or on electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In MEDICARE assigned cases, Gastroenterology Medical Clinic and/or its authorized agents, agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based on the charge determination of the MEDICARE carrier.

## PATIENT PRIVACY PRACTICES

Initials _____

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our Notice of Privacy Practices policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

## CONSENT TO TREATMENT AND RECORD RELEASE

Initials _____

I authorize Gastroenterology Medical Clinic to evaluate and treat me or my family member for any illness or injury for which I seek medical care. I have read and understand the above clinic policies and I further acknowledge that I accept the terms outlined in each of the above policies. I hereby authorize Gastroenterology Medical Clinic to release to my referring physician, insurance company, or legal guardian, any information, including diagnosis and records of treatment, concerning my medical history and care.

## TELEPHONE CONSUMER PROTECTION ACT (TCPA)

Initials _____

I agree that the facility, Gastroenterology Medical Clinic or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

## DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE

Initials _____

I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, Gastroenterology Medical Clinic will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Phone #: _____

Print Name: _____ Phone #: _____

Print Name: _____ Phone #: _____

## HIPAA ACKNOWLEDGEMENT

- I acknowledge that I have received access to the "Notice of Privacy Practices" for Gastroenterology Medical Clinic. I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize Gastroenterology Medical Clinic to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I have read and understand the "Physician's Consent" and the "Disclosure of Financial Interest".
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

X _____ _____

Patient or Guardian Signature Date

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# ABOUT TELEMEDICINE

## WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self management and caregiver support of the patient. Telemedicine services often provide a broader access to medical care, eliminate transportation concerns, and increase comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, e-mails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

## TELEMEDICINE ACKNOWLEDGEMENT

I have read and understand the information provided in this document. I have discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

X _____
Patient or Guardian Signature

_____
Date

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# CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.
2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.
3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.
4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.
5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with my doctor.
6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.
7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.
8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.
9. I understand the risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto remember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.
10. No part of the encounter will be recorded without my written consent.
11. I have the right to access my medical information and obtain copies of my medical records in accordance with California state law.
12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

## TELEMEDICINE CONSENT ACKNOWLEDGEMENT

I have read and understand the information provided in this Consent to Use of Telemedicine. I have discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

X _____ _____
Patient or Guardian Signature Date

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# PATIENT HISTORY FORM

Date _____

Name _____ Age _____ Sex M F Date of Birth _____

What is your main problem? _____

Have you had any relevant tests pertaining to this problem? E.g., labs, X-rays?

1. _____ 2. _____
3. _____ 4. _____

List any current medications, strength, and dosage.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

List any medication allergies. What reaction did you have?

1. _____ Reaction _____
2. _____ Reaction _____
3. _____ Reaction _____

List any previous surgeries that you have had.

| | *Type* | *Year* | *Hospital* | *City* | *Surgeon* |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

List any current medical problems or chronic illnesses.

| | *Problem* | *Date started* | *Current treatment* |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

Have you been hospitalized for any reason other than surgery?

| | *Reason* | *Date* | *Hospital* | *City* | *Physician* |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

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# PATIENT HISTORY FORM

## HABITS

_____ Cigarettes packs per day _____ how many years _____

_____ Alcohol type and amount _____

_____ Recreational drugs type and amount _____

_____ Coffee, tea, sodas type and amount _____

## FAMILY HISTORY

| | Known Illness/disease | Cause of death |
|---|---|---|
| Father | | |
| Mother | | |
| Brothers | | |
| Sisters | | |
| Other Relatives | | |

## SOCIAL HISTORY

Grade completed in school _____ Occupation _____

How many times have you been married? _____ Are you presently married? _____

Do you have any children? _____ How many? _____

Are you under any stress? _____ Explain _____

Have you recently been camping or exposed to unusual food/water? _____

Have you traveled outside the US? _____ Where? _____ When? _____

## WOMEN ONLY

At what age did you start menstruation? _____ Have you stopped? _____ When? _____

Menstrual cycle is every _____ days. Duration of your period _____

Number of: pregnancies _____ children _____

miscarriages _____ abortions _____

Explain any complications during pregnancy _____

Date of last pelvic exam _____ Pap smear _____ Results _____

Type of birth control used _____

Have you ever had venereal disease or syphilis? _____

## MEN ONLY

Prostate or testicular disease? _____ Venereal disease? _____

Patient's name _____ Date of birth _____ Today's date _____

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# PATIENT HISTORY FORM

## REVIEW OF SYSTEMS

Do you have, or have you ever had in the past, any of the following? (mark with an "X")

**Gastrointestinal**
_____ Disease of the esophagus
_____ Pain or trouble swallowing
_____ Food gets stuck
_____ Heartburn
_____ Hiatal hernia
_____ Recent nausea or vomiting
_____ Recent vomiting blood
_____ Recent stomach pain
_____ Ulcers
_____ Bowel obstruction
_____ Appendicitis or hernia
_____ Ileitis or colitis
_____ Recent abdominal cramps/pain
_____ Diverticulosis
_____ Recent loss of appetite
_____ Recent fever, chills, sweats
_____ Recent change in bowel habits
_____ Recent constipation
_____ Recent diarrhea
_____ Recent change in size of stool
_____ Recent blood in stool/rectal bleeding
_____ Black, tarry stools
_____ Hemorrhoids
_____ Recent loss of bowel control
_____ Gallbladder disease/stones
_____ Liver disease
_____ Hepatitis
_____ Exposure to hepatitis
_____ Blood transfusions
_____ Jaundice
_____ Pancreatitis
_____ Pancreatic disease

**Skin**
_____ Itching or rash
_____ Skin diseases

**HEENT**
_____ Blind spots
_____ Double or blurred vision
_____ Failing vision
_____ Eye pain, glaucoma
_____ Deafness
_____ Ringing in the ears
_____ Sinusitis
_____ Nose bleeds
_____ Hay fever
_____ Sore throats, tonsillitis

**Allergy**
_____ Hay fever
_____ Food allergies

**Pulmonary**
_____ Increasing sputum production
_____ Asthma/emphysema
_____ Bronchitis
_____ Pneumonia
_____ Lung tumor
_____ Other lung disease
_____ Shortness of breath
_____ Ankle swelling

**Cardiovascular**
_____ Heart attack
_____ Any heart valve disease
_____ Enlarged heart
_____ Chest pain
_____ Aneurysms
_____ High blood pressure
_____ Blood clots
_____ Phlebitis

**Hematologic**
_____ Anemia
_____ Bleeding tendencies
_____ Other blood diseases

**Genitourinary**
_____ Pus in urine
_____ Blood in urine
_____ Loss of urine control
_____ Kidney or bladder infections
_____ Kidney or bladder stones
_____ Other kidney diseases

**Rheumatologic**
_____ Swollen joints
_____ Aching muscles or joints
_____ Gout
_____ Lupus

**Endocrine**
_____ Diabetes
_____ Hyper or hypothyroidism
_____ Adrenal disease

**Neurologic**
_____ Headaches
_____ Blackouts
_____ Dizzy spells/lightheadedness
_____ Seizures, convulsions
_____ Weakness or paralysis
_____ Strokes
_____ Loss of sensation

**Psychiatric**
_____ Anxiety or depression
_____ Suicidal or homicidal ideas
_____ Nervous breakdown
_____ Psychiatric problems

Patient's name _____ Date of birth _____ Today's date _____