GASTROENTEROLOGY MEDICAL CLINIC

Serving Folsom and the Western Slope since 1985

NEW PATIENT REFERRAL FORM

PATIENT NAME: _____
Last First Mi.

~~~~~~

MAILING ADDRESS _____

CITY _____ ZIP _____

STREET ADDRESS _____

CITY _____ ZIP _____

DOB _____

HOME PHONE _____ WORK/CELL _____

~~~~~~

REFERRING PHYSICIAN _____

REASON FOR REFERRAL _____

_____

INSURANCE _____

AUTHORIZATION _____

~~~~~~

FORMS: MAILED/DATE _____
PICKED UP _____
DONE HERE _____

RECORDS: REQUESTED _____
NOT AVAIL _____
PT. HAND CARRY _____
CONTACT _____

LOGGED IN COMPUTER _____

TODAY'S DATE _____ TAKEN BY _____

Revised 10/13

1580 Creekside Drive, Ste. 220 • Folsom, CA 95630 • 916-983-4444 • Fax 916-983-8563
1000 Fowler Way, Ste. 7 • Placerville, CA 95667 • 530-622-6430 • Fax 530-622-1016
~~~~~~

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 a 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 your 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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CONFIDENTIAL PATIENT INFORMATION

(Please print legibly)

Name _____ Date of Birth _____ Age _____

_____ Sex M __ F __ Marital S ___ M ___ W ___ D ___ SEP ___

Mailing Address _____

Street Address _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Address _____

Occupation _____ How Long _____ Business Phone _____

SPOUSES INFORMATION

Spouse/Guardian _____ DOB _____

Employer _____ Address _____

Occupation _____ How Long _____ Business Phone _____

INSURANCE INFORMATION

Medicare # _____ MediCal # _____

Insurance Company _____ Subscriber _____

ID # _____ Group # _____ Coverage Code _____

Secondary Insurance _____ Subscriber _____

ID # _____ Group # _____ Coverage Code _____

OTHER INFORMATION

Emergency Contact (other than spouse) _____

Address _____ Phone _____

Referred by _____

Address _____ Phone _____

DRUG ALLERGIES _____

_____ _____

Signature of Responsible Party Date

FOR OFFICE USE ONLY: PATIENT # _____ REF PHYS # _____ INS # _____

Special Arrangements _____

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****The following "Assignment of Benefits" and "Medical Records Release" authorization is a necessary document in order for GASTROENTEROLOGY MEDICAL CLINIC to Bill for services rendered, and to receive payment directly from your insurance company.*

PRIVATE AND GROUP INSURANCES

I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and other health plans 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 the original. I understand that I am financially responsible for all charges that are not paid by insurance. I authorize GASTROENTEROLOGY MEDICAL CLINIC to release all information necessary to secure the payment.

SIGNED _____ *DATE:* _____
Beneficiary Signature

MEDICARE ASSIGNMENT AND AUTHORIZATION TO SUBMIT CLAIMS

I request that payment of authorized MEDICARE benefits be made on my behalf to GASTROENTEROLOGY MEDICAL CLINIC for any services furnished tome by any physicians associated with GASTROENTEROLOGY MEDICAL CLINIC.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand 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 insurances 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.

SIGNED: _____ *DATE:* _____
Beneficiary Signature

GASTROENTEROLOGY MEDICAL CLINIC
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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 test 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. _____ 5. _____ 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 that 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 you period _____
Number of: pregnancies _____ children _____
miscarriages _____ abortions _____
Explain any complications during pregnancy _____
Date of last pelvic exam _____ Pap smear _____ Results _____
Type of birth control pills 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
_____ Hiatus 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
_____ Hayfever
_____ 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 depressions
_____ Suicidal or homocidal ideas
_____ Nervous breakdown
_____ Psychiatric problems

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

DESIGNATION OF PERSONAL REPRESENTATIVE
DESIGNEE FOR RELEASE OF INFORMATION

DESIGNATION SECTION

ATTN: _____ Gastroenterology Medical Clinic
Representative

I, _____ (print name) hereby designate the following person to receive information on my behalf as my personal representative/designee with respect to my health and financial information.
_____ Last four digits of Social Security Number: _____
Print Name of Representative/Designee (Designee can be a relative, spouse, child, parent, friend, etc.)

The authority of this person when acting as my personal representative/designee is restricted the following functions:

___ This person is to be afforded all the privileges that would be afforded to me with respect to my health and financial information for all dates of service.

___ This person is to be afforded all the privileges that would be afforded to me with respect to my Health information only.

___ This person is to be afforded all the privileges that would be afforded to me with respect to my Financial information only.

___ This person is to be afforded all the privileges that would be afforded to me with respect to my health and financial information for only the following
Dates of service: _____

I understand that this designation does not expire until I revoke it in writing. I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Gastroenterology Medical Clinic. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health and financial information have already acted in reliance on the designation.

Patient's signature: _____ Date: _____

Last four digits of Social Security Number: _____

REVOCATION SECTION

I hereby revoke this designation of a personal representative/designee.

Patient's signature: _____ Date: _____

FINANCIAL POLICY

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.

REFERRALS/AUTHORIZATIONS: It is the responsibility of the patient to obtain a referral from his or her primary care physician prior to the scheduled visit if a referral is required by insurance to obtain services provided by a specialty provider. If a referral is not obtained, the patient accepts full financial responsibility for all services rendered.

CANCELLATIONS/FEES: If the patient is unable to keep a scheduled appointment or procedure, it is his or her responsibility to notify our office at least 24-hours prior to the scheduled appointment, or 48-hours prior to the scheduled procedure. Appointments cancelled after this time frame may be subject to a cancellation fee of $50.00. Additional fees may also be applied to requests for medical records and for physicians completing paperwork for patients (i.e. Disability, FMLA forms). These fees are not covered by insurance, and the patient accepts full financial responsibility for all additional fees.

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