



ARIZONA  
GASTROENTEROLOGY  
LLC.

**Financial agreement**

**\*\*Please read carefully the following financial agreement.** Please be sure to ask for clarification if you do not understand any part of this agreement. By signing this agreement you are indicating that you have read and understand all of it and will be held responsible for everything included in this financial agreement.

**\*\*It is your responsibility to know your benefits!** Contracts with insurance companies vary by employer if any. We can let you know if we are contracted with your **Insurance carrier**, but we do not know if we are contracted with **your specific plan**. **Our office sees hundreds of patients and it is impossible for our staff to know every single patient's detailed Insurance coverage.** So, it is up to you to check and make sure that our providers are on **your specific plan, meaning In Network**. It is also your responsibility to know your plan specifics such as; **Exclusions, Pre-existing Conditions, Deductibles, Co-Insurance and Non-Covered Charges**. We do not bill third party insurances such as auto, home, or workman's compensation. **If you are unsure of your insurance benefits, you will need to contact your carrier for clarification of your coverage.** You may always ask us for help in this matter if you need any specific codes required to verify coverage of procedures being done.

This office is not in the practice of changing or re-coding claims once they have been billed. This constitutes fraud, and will not be tolerated.

**\*\*It is your responsibility** to notify our office if there is a change of name, insurance coverage, address and/or phone number. If for any reason you do not update your information in a timely manner and it causes a claim denial, you will be responsible for the full balance of that claim. If you do not update your information and we cannot contact you about a balance on your account it will be sent to collections.

**\*\*Please also understand that we DO NOT bill as an outpatient facility**, these are procedures being done **in the office** we bill as place of service office this is not part of your outpatient/facility benefits. **Sonora Quest/Lab Corp and Anesthesia are separate** from Arizona Gastroenterology Clinic LLC., **meaning they do their own billing and they have their own Tax ID and NPI numbers**, you will also need to verify with your plan if they are **In Network with your specific plan**. These are the groups being used to send your Pathology claims as well as administer your anesthesia services in our office. This is why you may get a separate billing from these other groups. **We have no control over the processing of your specific benefits with these groups.** Below are the numbers for you to call directly if you may have any questions or need further information on pathology and anesthesia for billing/payment purposes.

LAB CORP—1-800-845-6167

SONORA QUEST—602-685-5000

Anesthesia Dr. Think Le Billing: Virginia 480-248-9516

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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TODAY'S DATE: \_\_\_\_\_

REFERRING DR: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

RACE: WHITE  BLACK/AFRICAN AMERICAN  ASIAN  AMERICAN INDIAN / ALASKA NATIVE

NATIVE HAWAIIAN/PACIFIC ISLANDER  UNKNOWN  DECLINE TO ANSWER

ETHNICITY: HISPANIC/LATINO  NON HISPANIC/LATINO  DECLINE TO ANSWER

SEX: M  F  PREFERRED LANGUAGE: ENGLISH  SPANISH  OTHER (PLEASE SPECIFY) \_\_\_\_\_

CONTACT PREFERENCE: LETTER  TELEPHONE CALL  OTHER (PLEASE SPECIFY) \_\_\_\_\_

SOCIAL HISTORY: OCCUPATION: \_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED  OTHER

ALCOHOL: NONE  OCCASIONALLY  DAILY  OTHER \_\_\_\_\_ TYPE: BEER  WINE  LIQUOR

CAFFEINE: TEA  COFFEE  SODA  EXERCISE: TYPE \_\_\_\_\_

TOBACCO: CURRENT SMOKER  OCCASIONAL SMOKER  FORMER SMOKER  HEAVY SMOKER   
LIGHT SMOKER  NEVER SMOKED

DRUG USE: YES  NO  IF YES, TYPE OF DRUGS USED: \_\_\_\_\_

ALLERGIES: NONE  SULFA  PENICILLINS  IODINE  CODEINE SULFATE  PROPOFOL  ASPRIN/NSAIDS

LATEX  OTHER: \_\_\_\_\_

CURRENT MEDICATIONS: (PLEASE INCLUDE NAME, DOSE, AND HOW TAKEN) EXAMPLE: TYLENOL 325MG 2 X A DAY

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DIAGNOSTIC STUDIES/TESTS: NONE

CT ABDOMEN <input type="checkbox"/>	ABDOMINAL US <input type="checkbox"/>	MRI ABDOMEN <input type="checkbox"/>	COLONOSCOPY <input type="checkbox"/>	ENDOSCOPY <input type="checkbox"/>
WHEN: _____	WHEN: _____	WHEN: _____	WHEN: _____	WHEN: _____

**PAST OR PRESENT MEDICAL CONDITIONS:** NONE

- |  |  |  |  |  |
|--|--|--|--|--|
| ACID RELUX <input type="checkbox"/><br>WHEN: _____     | ANEMIA <input type="checkbox"/><br>WHEN: _____           | BARRETTS ESOPHAGUS <input type="checkbox"/><br>WHEN: _____ | BLEEDING ULCER <input type="checkbox"/><br>WHEN: _____       | BREAST CANCER <input type="checkbox"/><br>WHEN: _____  |
| CIRRHOSIS <input type="checkbox"/><br>WHEN: _____      | COLITIS <input type="checkbox"/><br>WHEN: _____          | COLON CANCER <input type="checkbox"/><br>WHEN: _____       | COLON POLYPS <input type="checkbox"/><br>WHEN: _____         | DIVERTICULITIS <input type="checkbox"/><br>WHEN: _____ |
| DIABETES <input type="checkbox"/><br>WHEN: _____       | ELEVATED LFT'S <input type="checkbox"/><br>WHEN: _____   | GALLSTONES <input type="checkbox"/><br>WHEN: _____         | GASTRIC ULCER <input type="checkbox"/><br>WHEN: _____        | GASTRITIS <input type="checkbox"/><br>WHEN: _____      |
| GERD <input type="checkbox"/><br>WHEN: _____           | H. PYLORIC <input type="checkbox"/><br>WHEN: _____       | HEPATITIS <input type="checkbox"/><br>WHEN: _____          | HEPATITIS B <input type="checkbox"/><br>WHEN: _____          | HEPATITIS C <input type="checkbox"/><br>WHEN: _____    |
| HIATAL HERNIA <input type="checkbox"/><br>WHEN: _____  | IBS <input type="checkbox"/><br>WHEN: _____              | MORBID OBESITY <input type="checkbox"/><br>WHEN: _____     | PACEMAKER <input type="checkbox"/><br>WHEN: _____            | PEPTIC ULCER <input type="checkbox"/><br>WHEN: _____   |
| GASTRIC BYPASS <input type="checkbox"/><br>WHEN: _____ | HYPERTENSION/HBP <input type="checkbox"/><br>WHEN: _____ | PANCREATITIS <input type="checkbox"/><br>WHEN: _____       | HYPERCHOLESTEROLEMIA <input type="checkbox"/><br>WHEN: _____ |  |

OTHER: PLEASE INCLUDE DATES: WHEN: \_\_\_\_\_

**PREVIOUS PROCEDURES:** NONE

- |  |  |  |  |
|--|--|--|--|
| COLON SURGERY <input type="checkbox"/> | SMALL BOWEL SURGERY <input type="checkbox"/> | CHOLECYSTECTOMY <input type="checkbox"/> | HERNIA REPAIR <input type="checkbox"/> |
| WHEN: _____                            | WHEN: _____                                  | WHEN: _____                              | WHEN: _____                            |

OTHER: PLEASE INCLUDE DATES: WHEN: \_\_\_\_\_

**FAMILY HISTORY:**

Any first degree relative (parent, sibling, child) with colon cancer? If yes who? \_\_\_\_\_

Are they living? YES  NO  If no, what age did they pass away? \_\_\_\_\_

Any other gastrointestinal or liver diseases in the family? YES  NO  If yes who? \_\_\_\_\_

**Please mark all symptoms you are currently having:**

- Nausea  Vomiting  Belching  Constipation  Diarrhea  Tenesmus (rectal pain)   
 Blood in stool  Hematemesis (vomiting blood)  Melena  Abdominal Swelling   
 Abdominal Pain  Where? \_\_\_\_\_ Change in Bowel Habits  Gas  Heart Burn  Jaundice   
 Rectal Bleeding  Stomach Cramps  Dysphagia  Odynophagia to solids/liquids  Early satiety   
 Anorexia  Weight Change

Other Symptoms: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, ST, ZIP: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Sex: ( ) M ( ) F  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: ( ) M ( ) S ( ) W ( ) D  
Social Security Number: \_\_\_\_\_

Patients local Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patients out of State Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Phone Numbers:**

Home: ( ) \_\_\_\_\_ Email address: \_\_\_\_\_  
Cell: ( ) \_\_\_\_\_  
Work: ( ) \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

DO YOU HAVE AN ADVANCED DIRECTIVE? **YES NO** POWER OF ATTORNEY? **YES NO**  
DO YOU HAVE A PACEMAKER? **YES NO** If yes, WE WILL NEED A COPY OF YOUR PACEMAKER ID CARD.  
DO YOU HAVE AN ASSIGNED LEGAL GUARDIAN? **YES NO** If yes, We will need a copy of the legal documents to support this.

\*\*\*\*\***THE FOLLOWING MUST BE COMPLETED BY PATIENT**\*\*\*\*\*

**INSURANCE INFORMATION: (Please present Insurance Card and Photo id to receptionist)**

**PRIMARY:**

Insurance Company Name: \_\_\_\_\_ Policy Holder/Sponsor: \_\_\_\_\_  
Employer: \_\_\_\_\_ Policy Holder Id Number: \_\_\_\_\_  
Policy or ID Number: \_\_\_\_\_ Policy Holder/Sponsor D.O.B. \_\_\_\_\_  
Ins Co. Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**SECONDARY:**

Insurance Company Name: \_\_\_\_\_ Policy Holder/Sponsor: \_\_\_\_\_  
Employer: \_\_\_\_\_ Policy Holder Id Number: \_\_\_\_\_  
Policy or ID Number: \_\_\_\_\_ Policy Holder/Sponsor D.O.B. \_\_\_\_\_  
Ins Co. Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**\*Note:** This information will become part of you Protected Medical Records and will be released ONLY with your written consent.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**\*\*\*\*PLEASE DO NOT LEAVE THIS PAGE BLACK\*\*\*\***

**REQUEST FOR DISCLOSURE OF HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Previous Name:** \_\_\_\_\_

I request that Arizona Gastroenterology Clinic LLC may disclose my protected health information (PHI) **ONLY to FAMILY/FRIENDS listed below:**

**\*\*Do NOT include your Primary Care Physician/Family Dr. as they are copied on all records\*\***

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

\*\*\*I understand that any restrictions agreed to by Arizona Gastroenterology Clinic LLC do not apply to use or Disclosure of my PHI by Arizona Gastroenterology Clinic for emergency medical care or as otherwise Provided by law.

\_\_\_\_\_  
**Patient or legally authorized individual signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name If signed on behalf of the patient**

\_\_\_\_\_  
**Relationship to patient**

## CONSENT AND ASSIGNMENT OF BENEFITS

The Department of Health and Human Services began enforcing regulations designed by the Health Insurance Portability and Accountability Act (HIPAA) on April 14, 2003. In keeping with the regulations imposed by this act, our practice will provide services when the patients agree to:

- Sign this consent allowing us to use your protected health information to collect payment for services, or
- Upon receipt of cash for the service on the day of the visit.

### CONSENT

I agree to permit my protected health information to be used and disclosed for purpose of treatment, payment and health care operation.

For details about these uses and disclosures, please see our Privacy Notice. We reserve our right, as your health care provider, to change our Privacy Policies described in the Privacy Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment of health care operations. We are not required to agree with this request, but if we do, we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have already taken action in reliance upon the use or disclosure of your information.

I consent to the assignment of benefits directly to the physicians and understand that I may be responsible for non-covered charges as allowed by my insurance carrier.

Please be advised that we require 24 hour notice for any appointment changes or cancellations. Failure to provide this notice may result in a **fee of \$50.00.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## ACKNOWLEDGMENT OF RECEIPT OF PATIENTS RIGHTS/PRIVACY NOTICE

I acknowledge that I have received or given the opportunity to read a copy of Arizona Gastroenterology Clinic's Notice of Privacy Practices. It can be found attached to this Clipboard in a page protector.

\_\_\_\_\_  
Patient or Legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of patient

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Documentation of Good Faith Efforts to obtain acknowledgment of receipt of privacy notice.  
(for use when acknowledgment cannot be obtained from the patient)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of patient Encounter

The patient presented to the office and was provided with a copy of the office's notice of privacy practices. A good faith effort was made to obtain from the patient or patient's representative, if applicable, a written acknowledgment of his/her receipt of the notice. However, such acknowledgement was not obtained because:

- patient refused to sign.
- patient representative refused to sign.
- the patient had a medical emergency and an attempt to obtain the acknowledgment will Be made at the next available opportunity.
- patient was unable to sign or initial because \_\_\_\_\_

\_\_\_\_\_  
AGLC Employee signature

\_\_\_\_\_  
Date