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. **LabCorp (DIANON) (Pathology Company) and Endoscopy Anesthesia Service PLLC are separate** from Arizona Gastroenterology Clinic LLC., **meaning they do their own billing and they have their own Tax ID and NPI numbers.** 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 bill from these other groups.

We have no control over the processing of your specific benefits with these groups.

PRINT 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 ❑ OTHER ❑ DECLINE TO ANSWER ❑

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

SEX: M ❑ F ❑ **PREFERRED LANGUAGE:** ENGLISH ❑ SPANISH ❑ OTHER (PLEASE SPECIFY)_____

SOCIAL HISTORY: OCCUPATION: _____ NUMBER OF CHILDREN: _____

MARITAL STATUS: SINGLE ❑ MARRIED ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED ❑ OTHER ❑

ALCOHOL TYPE: BEER ❑ WINE ❑ LIQUOR ❑ **FREQUENCY:** NONE ❑ OCCASIONALLY ❑ DAILY ❑

CAFFEINE: TEA ❑ COFFEE ❑ SODA ❑ NONE ❑

EXERCISE TYPE: _____NONE ❑

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 (DRUG/MEDICATION): _____

IMMUNIZATIONS: None ❑

PNEUMONIA (PCV13) ❑ Tdap/Td❑ HEPATITIS A, B,C ❑ SHINGLES ❑ INFLUENZA❑

YEAR: _____ YEAR:_____ YEAR:_____ YEAR:_____ YEAR:_____

CURRENT MEDICATIONS: (PLEASE INCLUDE NAME AND DOSE) **EXAMPLE:** TYLENOL 325MG

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

DIAGNOSTIC STUDIES/TESTS (IN THE LAST 6 MONTHS): NONE ❑

CT ABDOMEN ❑ ABDOMINAL US ❑ MRI ABDOMEN ❑ COLONOSCOPY ❑ ENDOSCOPY ❑
WHERE:_____ WHERE:_____ WHERE:_____ WHERE:_____ WHERE:_____

PAST OR PRESENT MEDICAL CONDITIONS: NONE ❑

ACID RELUX ❑ WHEN:_____ ANEMIA ❑ WHEN:_____ BARRETTS ESOPHAGUS ❑ WHEN:_____ BLEEDING ULCER ❑ WHEN:_____ BREAST CANCER ❑ WHEN:_____

CIRRHOSIS ❑ WHEN:_____ COLITIS ❑ WHEN:_____ COLON CANCER ❑ WHEN:_____ COLON POLYPS ❑ WHEN:_____ DIVERTICULITIS ❑ WHEN:_____

DIABETES ❑ WHEN: _____ ELEVATED LFT'S ❑ WHEN: _____ GALLSTONES ❑ WHEN: _____ GASTRIC ULCER ❑ WHEN: _____ GASTRITIS ❑ WHEN: _____

GERD ❑ WHEN: _____ H. PYLORIC ❑ WHEN: _____ HEPATITIS ❑ WHEN: _____ HEPATITIS B ❑ WHEN: _____ HEPATITIS C ❑ WHEN: _____

HIATAL HERNIA ❑ WHEN: _____ IBS ❑ WHEN: _____ MORBID OBESITY ❑ WHEN: _____ PACEMAKER ❑ WHEN: _____ PEPTIC ULCER ❑ WHEN: _____

GASTRIC BYPASS ❑ WHEN: _____ HYPERTENSION (HBP) ❑ WHEN: _____ PANCREATITIS ❑ WHEN: _____ HYPERCHOLESTEROLEMIA ❑ WHEN: _____

MIOCARDICAL INFARCTION (HEARTATTACK) ❑ WHEN: _____ ISCHEMIC VASCULAR DISEASE (IVD) ❑ WHEN: _____

PREVIOUS PROCEDURES: NONE ❑

COLON SURGERY ❑ WHEN: _____ SMALL BOWEL SURGERY ❑ WHEN: _____ CHOLECYSTECTOMY ❑ WHEN: _____ HERNIA REPAIR ❑ 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❑ Change in Bowel Habit ❑ 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 AVDANCED 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:** _____

REQUEST FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ D.O.B. _____

Previous Name: _____

I request that Arizona Gastroenterology & Liver Clinic 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 & Liver Clinic do not apply to use or Disclosure of my PHI by Arizona Gastroenterology & Liver 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 proctected 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