Name:_____ Date of Birth:_____

Comprehensive GI Care

A Professional Medical Group, Inc.

Lisa Hertz, M.D. • Kashyap Trivedi, M.D.

4772 Katella Avenue Suite 200 • Los Alamitos, CA 90720
Phone (562) 596-5552 • Fax (562) 596-5340

Direct Screening Colonoscopy Form

Please complete our Direct Screening Colonoscopy form (print or type directly into the PDF). You can mail/ fax/ or drop off to our office or email the completed form to our HIPAA-compliant email address at **cgicare@cgicare.hush.com**. Once we receive and review your Direct Screening Colonoscopy form, our office will contact you for an appointment. If able, please provide any medical records that pertain to your appointment when submitting your Direct Screening Colonoscopy form. **If you are unable to provide medical records, please complete the highlighted fields and sign the attached release of records form so we can fax it to the appropriate doctor/facility.**

Which physician would you like to perform your Direct Screening Colonoscopy? Please check one.

◯ Dr. Lisa Hertz
◯ Dr. Kashyap Trivedi

Please provide a photo copy of the following REQUIRED:

☐ Photo I.D.
☐ Insurance card(s) (front and back)

Please check/provide the following below that apply:

☐ **Labs** (blood work drawn within the past 1 year)

Name of laboratory (EX: Quest Diagnostics, LabCorp):_____

Date of collection: _____

☐ **Abdominal imaging** (x-ray, CT, MRI, etc.)

Name of facility: _____

Type of imaging (example: MRI of abdomen): _____

☐ **Procedures** (Colonoscopy, EGD [esophagogastroduodenoscopy], etc.)
Please see page 3 titled "Colonoscopy and Endoscopy History"

☐ **Hospitalization** (admitted or emergency room)
Please see page 3 titled "Hospitalization History"

☐ **I am unable to provide the records selected above. I will contact the following physician for these records**

Physician's name: _____
Phone number: _____

Sincerely yours,

Comprehensive GI Care

Name:_____ Date of Birth:_____

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REASON FOR CONSULTATION: _____

MEDICAL HISTORY:

Please check any medical problems that you have or have had in the past:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Gastroesophageal reflux
- ☐ Barrett's esophagus
- ☐ Blood transfusion
- ☐ Cancer (Where? _____)
- ☐ Chronic pain
- ☐ Cirrhosis of liver
- ☐ Colon polyps
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ COPD / Emphysema
- ☐ Fatty liver
- ☐ Heart disease / Heart attack
- ☐ Hemorrhoids
- ☐ Hepatitis (Hepatitis A, B and/or C)
- ☐ Hiatal hernia
- ☐ Hypothyroidism
- ☐ Hypertension/High blood pressure
- ☐ Inflammatory bowel disease
  - ☐ Ulcerative colitis
  - ☐ Crohn's disease
- ☐ Irregular heartbeat (e.g. Afib)
- ☐ Joint replacement
- ☐ Obesity
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ **Sleep Apnea**
- ☐ Stroke
- ☐ Ulcer disease

Please list any additional significant medical problems not noted above

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICATION LIST:

Please list all medications & supplements, **including herbs, vitamins, injections, etc.** that you take. List everything even if you take it only occasionally. Please don't forget weekly or monthly meds. If not enough space, please attach list.

NAME	DOSE	FREQUENCY		NAME	DOSE	FREQUENCY
EX: Atorvastatin	*40 mg*	*1 tablet once a day*		*EX: Atorvastatin*	*40 mg*	*1 tablet once a day*

Name:_____ Date of Birth:_____

ALLERGIES:

Please list any allergies you have to medications and the reaction that you have. Also list any other allergies below, such as, gluten, grass, shellfish, etc. If the lines below do not provide enough space, please attach a list.

NAME	REACTION		NAME	REACTION

SURGICAL HISTORY:

Please list any surgeries starting from the most recent. If the lines below do not provide enough space, please a attach list.

DATE	FACILITY WHERE SURGERY PERFORMED	SURGERY
EX: 01/XXXX	***Los Alamitos Medical Center***	***Laparoscopic cholecystectomy***

HOSPITALIZATION HISTORY:

Please list any hospitalizations, **INCLUDING INPATIENT STAYS AND EMERGENCY ROOM VISITS**, starting from the most recent. If the lines below do not provide enough space, please attach a list

DATE	HOSPITAL NAME	REASON FOR HOSPITALIZATION/ER VISIT
EX: 01/XXXX	***Long Beach Medical Center***	***Abdominal pain (admitted)***

COLONOSCOPY AND ENDOSCOPY HISTORY:

Please list all colonoscopies, upper endoscopies (EGD), and flexible sigmoidoscopies from the most recent. If the lines below do not provide enough space, please attach a list.

DATE	PROCEDURE TYPE	PROVIDER AND LOCATION OF FACILITY
EX: 01/XXXX	***Endoscopy and Colonoscopy***	***Dr. Smith – Long Beach Endoscopy Center***

Name:_____ Date of Birth:_____

FAMILY HISTORY:

Check below the problems that your family members have had. State the age when they had the problem if you know it.

☐ I was adopted so I do not know my family history.

Member	Mother	Father	Siblings	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Colon Polyps								
Colon Cancer								

COMMENTS/OTHER FAMILY HISTORY:

_____

SOCIAL HISTORY:

Do you currently smoke? ◯ Y / ◯ N
If yes, how much? _____
Are you ready to quit smoking? ◯ Y / ◯ N
Have you ever smoked? ◯ Y / ◯ N
If yes, what year did you quit? _____

How many alcoholic beverages do you consumer per week? _____

Marital status: ◯ Single ◯ Married ◯ Widowed ◯ Significant other ◯ Other: _____

REVIEW OF SYSTEMS (PLEASE CHECK IF APPLICABLE TO YOU)

GENERAL:

☐ Fevers/night sweats ☐ Decreased appetite
☐ Weight loss ☐ Weight gain
☐ Fatigue/weakness

Do you require antibiotics prior to dental work?
☐ Y ☐ N

Have you had any antibiotics in the past year?
☐ Y ☐ N if so, when? _____

Current weight: _____ Height: _____
Weight one month ago: _____
Weight six months ago: _____

GASTROINTESTINAL

☐ Abdominal pain ☐ Diarrhea
☐ Hemorrhoids ☐ Esophageal Reflux
☐ Constipation ☐ Blood in stool

Number of bowel movements per day:

☐ 0-1/day ☐ 2-3/week (usually constipated)
☐ 1-2/day ☐ other (pls. explain):
☐ 3+/day _____

Name any gastrointestinal (GI) doctors you have seen in the past: _____

ENT/RESPIRATORY:

☐ Sleep apnea

CARDIOVASCULAR:

☐ Chest pain ☐ Palpitations
☐ Irregular heartbeat ☐ Heart murmur

Cardiologist name:

_____

PULMONARY:

☐ Shortness of breath ☐ Asthma
☐ Wheezing

Pulmonologist name:

_____

HEMATOLOGY:

☐ Bruise/bleed easily ☐ Clotting disorder
☐ Anemia

Do you take any of the following blood thinners? (Select those that apply):

☐ Aspirin 81 mg or 325 mg ☐ Lovenox (Enoxaparin)
☐ Plavix (Clopidogrel) ☐ Eliquis (Apixaban)
☐ Coumadin (Warfarin) ☐ Brilinta (Ticagrelor)
☐ Xarelto (Rivaroxaban) ☐ Other: _____

Hematologist/Oncologist name

_____

Name:_____ Date of Birth:_____ Gender: ◯F ◯M ◯Non-Binary

PATIENT INFORMATION FORM

REFERRED BY: _____ **PHONE # (_____) _____ - _____**

Primary Care Physician: _____ **PHONE # (_____) _____ - _____**

LOCAL Pharmacy name & city: _____ **PHONE # (_____) _____ - _____**

Patient Address:_____ _____ _____ ____ _____
STREET ADDRESS APT. # CITY STATE ZIP

Home phone: **(_____) _____ - _____** Cell Phone: **(_____) _____ - _____** Work Phone **(_____) _____ - _____**

Email: _____ Last 4 Social Security#: _____ Employer:_____ Occupation: _____

Preferred language: ◯ English ◯Spanish ◯Other: _____

Marital status: ◯ Single ◯Married ◯Widowed ◯Other Spouse/Partner's name:_____

Race: ◯American-Indian ◯Asian ◯African-American ◯Caucasian ◯Hispanic ◯Other:_____

Primary insurance name: _____ Subscriber ID #:_____ Group #:_____

Name of subscriber: _____ Relationship to patient: _____ DOB: _____

Insurance Address: :_____ _____ ____ _____
STREET ADDRESS CITY STATE ZIP

Secondary insurance name: _____ Subscriber ID #:_____ Group #:_____

Name of subscriber: _____ Relationship to patient: _____ DOB: _____

Insurance Address: :_____ _____ ____ _____
STREET ADDRESS CITY STATE ZIP

Emergency contact: _____ _____ **PHONE # (_____) _____ - _____**
LAST NAME FIRST NAME

Relationship to patient:_____

Address: (if different than patient) _____ _____ _____ ____ _____
STREET ADDRESS APT. # CITY STATE ZIP

CONSENT TO TREAT: The undersigned consents to healthcare encompassing routine diagnostic procedures, medical treatment, and other services rendered to the patient by Comprehensive GI Care and/or associates.

NO GUARANTEES: It is understood that the practice of medicine and surgery and the rendering of healthcare is not an exact science. Therefore, no guarantees have been made as to the results of treatments, examinations, or other health services rendered by Comprehensive GI Care and/or associates.

ASSIGNMENT OF BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Comprehensive GI Care of any insurance benefits otherwise payable to or on behalf of the undersigned for treatment and health care services rendered by Comprehensive GI Care and/or Associates at a rate not to exceed Comprehensive GI Care normal charges. It is agreed that payment to Comprehensive GI Care pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

RELEASE OF MEDICAL RECORDS: The undersigned agrees that, to the extent necessary, to determine liability for payment and to obtain reimbursement. Comprehensive GI Care and/or associates may disclose portions or the patient's records, including his/her medical records to any person or entity which may be liable for all or any portion of medical charges. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.

CERTIFICATION: The undersigned certifies that he/she has read the foregoing, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute this agreement and to accept its terms.

_____ _____
SIGNATURE – PATIENT/GUARDIAN/CONSERVATOR/OTHER **DATE:**

_____ _____
IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP **DATE:**

FINANCIAL POLICY

Thank you for allowing us to participate in your healthcare. We are committed to your treatment being successful and as pleasant as possible.

In the day and age of various health care plans including Medicare, private insurance, and other medical insurance, we understand the medical insurance field can be quite confusing. Please read and sign. Thank you.

1. **MEDICARE PATIENTS:** We are contracted providers with Medicare and accept assignment on all your claims. You are responsible for all deductible and co-insurance balances. If you have a secondary or supplemental insurance, we will be glad to bill as a courtesy to you. If you only have Medicare, your 20% copay is due upon receipt of the Medicare payment. Failure to do so puts your physician in jeopardy with Medicare.

2. **MEDI-CAL AND COVERED CALIFORNIA (OBAMA CARE PLANS/AFFORDABLE CARE ACT):** We are **NOT** contracted with Medi-Cal and **SOME** Covered California Plans. Patients with Medi/Medi plans may be responsible for the Medi-Cal portion of the claim, payable at time of service

3. **PRIVATE INSURANCE:** We bill your insurance as a courtesy. You may be responsible for a percentage of physician's fees as well as your deductible and/or co-insurance. It is the patients' responsibility to be aware of any deductible balance or copay. You may also need authorization to be seen and/or for procedures. If you have any questions, call your insurance company.

4. **COPAYS:** Due at time of service .

5. **MANAGED CARE PLANS:** Because our providers are specialists, you have been referred to us by your primary care provider. You are responsible for ensuring that we have an authorization, if necessary. We are responsible for obtaining future authorizations for any follow-up care.

6. **NO INSURANCE:** Payment in full is due at time of service.

7. **METHODS OF PAYMENT:** We accept cash, check and credit cards. We can also approve a payment plan agreed to by our financial counselor, if necessary.

8. **APPOINTMENTS:** We are happy to re-schedule your appointment. We would appreciate you giving us 24-hour notice. **A fee of $50 will be charged if less than 24 hour notice is given for an office visit. If a procedure is cancelled, we require 72 hour notice or $100 will be charged.** If you miss three consecutive appointments without prior notice, you will be dismissed from the practice.

9. **OPEN ACCOUNTS:** We will do everything possible to make it easy for you to take care of your financial obligations. We would appreciate a phone call in the event you are experiencing financial difficulties and require a payment arrangement.

10. **ASSIGNMENT OF BENEFITS:** You will be asked to sign an assignment of benefits form. If you receive payment, please remit in full to our office to ensure your account can be properly credited.

11. **REQUESTS FOR FORMS/LETTERS:** A fee of $25.00-$50.00 per form will be charged, depending on complexity, for completion of any forms/letters such as disability, family medical leave, jury duty, workers compensation, FAA license, military leave, travel agencies, etc. Your understanding of this necessity is greatly appreciated.

Thank you for trusting us with your care and if you have any questions, please do not hesitate to contact the office.

I have read and understood the above information. I agree to comply with this financial policy.

Name:_____ **Date of Birth:** _____

Signature:_____ **Date:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I may request a copy of your *"Notice of Privacy Practice"* containing a complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its *"Notice of Privacy Practice"* from time to time and that I may contact this organization at this address above to obtain a copy of the *"Notice of Privacy Practice"*.

I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide by the privacy restrictions stated in your *"Notice of Privacy Practice".*

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such a sending correspondence to the individual's office instead of the individual's home. This office will generally contact patients by written communication or phone calls. We will send letters to you or call the numbers which you have provided us on your patient information sheet.

Home Telephone

- ⦿ Okay to leave message with detailed information
- ○ Leave message with call-back number only

Cellphone

- ⦿ Okay to leave message with detailed information
- ○ Leave message with call-back number only

Work Telephone

- ⦿ Okay to leave message with detailed information
- ○ Leave message with call-back number only

Written Communication

- ⦿ Okay to mail to my home address
- ○ Please mail to another address: _____

The Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for uses or disclosures made pursuant to an authorization requested by the individual.

Record of Disclosure of Protected Health Information

I,_____, **authorize** the office of Comprehensive GI Care to contact the following person(s), such as a spouse, relative, etc. (**EXCLUDING YOURSELF, PCPs, AND REFERRING MDs**), if needed, regarding my medical information.

Name/Relationship	**Telephone number**	**Name/Relationship**	**Telephone number**

Patient Name	**Patient Signature**	**Date**

HIPAA- Compliant
Request of the Release of Medical Records

Persons Authorized to Disclose Information (Who records are being requested from)

_____

_____

Person(s) to Whom Information Will Be Disclosed
Information described above may be disclosed to:

Comprehensive GI Care Phone: (562) 596-5552
4772 Katella Avenue Suite 200 Fax: (562) 596-5340
Los Alamitos, CA 90720

Information to Be Used or Disclosed
The information covered by this authorization includes:

☑ Lab work (last 6 months), other relevant labs (CBC, CMP, CRP, Stool studies, IBD panel)
☑ Endoscopy and colonoscopy reports and pathology results
☑ Imaging (Relevant CT scans, abdominal ultrasounds, x-rays)
☑ Consult notes
☐ OTHER: _____

Purpose of Disclosure
Information listed above will be disclosed for the following purposes:

☑ Continuity of patient care
☐ Other: _____

Expiration Date of Authorization
This authorization is effective through **12/31/2025** unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Privacy Officer at 4772 Katella Ave. Suite 200 Los Alamitos, California 90720.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent.

Rights of the Individual
- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization

Effect of Refusing Authorization
If you refuse to sign this authorization, the Practice will not deny any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure of others, including:

_____

Patient Name:_____ **Date of Birth:** _____ **Last 4 SSN#:**_____ **Date:**_____

Signature:_____ **Witness's Signature**: _____

Patient Representative (Only for patients who is a minor or unable to sign): _____

Relationship: _____ Signature of Patient Representative:_____ Date:_____

Colonoscopy Worksheet (optional)
Know What You Will Owe

This informational page is to help patients better understand billing guidelines for colonoscopies and what questions to ask their insurance carrier before the procedure. Do not return this page to the provider with your patient packet, however please use it as a guideline/ worksheet if you choose to contact your insurance. Thank you.

Three categories in which your colonoscopy may fall under:

- **Diagnostic Therapeutic Colonoscopy**

Patient has past and/or present gastrointestinal symptoms, polyps, GI disease or anemia(s).

- **Surveillance/High Risk Screening Colonoscopy**

Patient is asymptomatic (no gastrointestinal symptoms either past or present), 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 years)

- **Preventive Colonoscopy Screening:**

Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, 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)

Who will bill me? You may receive bills for separate entities associated with your procedure, such as the physician, facility, anesthesia, pathologist, and/or laboratory. We can only provide you with information associated with our fees.

Is the office visit consultation covered for a preventative colonoscopy screening? An office visit prior to a preventative colonoscopy screening is included in the fee for the colonoscopy. If however, during your office visit, the provider manages a symptom or relevant medical history information, your insurance may be billed for the medical service and you will be responsible for any applicable copay, coinsurance, and/or your annual deductible.

How will I know what I will owe?

Based on the information above (colonoscopy type patient falls under), please call your insurance carrier and verify the benefits and coverage by asking the following questions.

1. Is the provider an in network or out of network provider?
2. Is the procedure code covered under my policy? ◯ Yes ◯ No

3. Will the procedure be processed as preventative, surveillance or diagnostic and what are my benefits for that service? (Results may vary based on how the insurance company recognizes the diagnosis).

Diagnostic/Medical Necessity Benefits

Deductible: _____ Coinsurance Responsibility: _____

Preventative/Wellness/Routine Colonoscopy Benefits:

Are there age and/or frequency limits for my colonoscopy? (E.G. one every 10 years over the age of 50, one every two years for a personal history of polyps beginning at age 40 etc.)

◯ No ◯ Yes, if so: _____

Deductible: _____ Coinsurance Responsibility: _____

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

◯ No ◯ Yes

Representative's Name: _____ Call Reference #: _____ Date: _____

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

If your insurance plan has a high deductible and has not been met, you may be asked to make a deposit prior to your procedure.