ADVANCED GI INC

PATIENT REGISTRATION FORMS

☐New Registration ☐ Updated Registration Gender☐ Male ☐ Female Marital Status☐ Married ☐ Single ☐Divorced ☐ Widowed

Name (First, MI, Last): ____________________ Date of Birth: __________ SS #: __________

Mailing Address: ____________________ City: __________ Zip: __________

Address: ____________________ City: __________ Zip: __________

Primary Ph: (   ) __________ Cell: (   ) __________ Alt Phone: (   ) __________

E-mail: ____________________ Driver's Lic: __________

Race: □ White / Caucasian □ Black or African American □ Asian □ Hispanic / Latino □ American Indian / Alaska Native □ Native Hawaiian / Other Pacific Islander □ Mixed □ Other □ Unknown □ Patient declines to provide information

Ethnicity: □ Hispanic / Latino □ Not Hispanic / Latino □ Patient declines to provide information

Referring MD: ____________________ **Primary Care** MD: ____________________

Phone: (   ) ____________________ Phone: (   ) ____________________

How did you hear about us? ☐ MD Name: __________ ☐ Friend ☐ Family ☐ Los Robles Hospital ☐ News Paper __________ ☐ On-Line __________ Other __________

Pharmacy (Our office has the ability to send medications electronically to your preferred pharmacy):

Do you consent for our staff to obtain your current Pharmacy records/prescriptions (Electronic Prescriptions)? ☐ Yes ☐ No

Current Pharmacy to send Prescriptions: ____________________ Ph (   ) __________

Address City State Zip

Emergency Contacts "NOT" Living with you:

Name: Relationship: Phone: (   )

Patient Employment Information

☐ Employed ☐ Retired ☐ Unemployed ☐ Student

Employer Name: ____________________

Address: ____________________ City: __________ Zip: __________

Phone: Occupation:

Insurance Information (If you are Insured through someone else, please list that persons information below)

Ins. Company Name: ____________________ Member ID #: ____________________

Group/Policy #: ____________________ Subscriber's Name: ____________________

Subscriber's Employer: ____________________ Subscriber's SSN: ____________________

Subscriber's Employer Address: ____________________ Subscriber's Date of Birth: ____________________

Subscriber's Employer Phone: ____________________ Relationship to Patient: ____________________

Secondary Insurance

Ins. Company Name: ____________________ Member ID #: ____________________

Group/Policy #: ____________________ Subscriber's Name: ____________________

Subscriber's Employer: ____________________ Subscriber's SSN: ____________________

Subscriber's Employer Address: ____________________ Subscriber's Date of Birth: ____________________

Subscriber's Employer Phone: ____________________ Relationship to Patient: ____________________

Please continue on the back of this form.

INSURED PATIENT PAYMENT POLICY

Patient Responsibility: You are responsible for all charges resulting from treatment provided by **AGI** (Advanced Gastroenterology, Inc.), we bill most insurance carriers. However, primary responsibility for the account is yours. Your co-payment is due at the time of service; any remaining balance owed by you is due when statement is received, unless other financial arrangements are made. If you have a delinquent balance, you will be expected to pay on next visit. Surgery scheduled once all accounts are current and paid in full, or if other arrangements have been made ahead of time (such as payment schedule).

Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s)/Guardian(s).
You are responsible for notifying **AGI** of any cancellations or changes to scheduled appointments or procedures.

Insurance Billings: It is the patient's responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes you **must** provide the new insurance information to **AGI** prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.

Statements: Payment is due upon receipt. **AGI** (Advanced Gastroenterology, Inc.) reserves the right to charge a $25.00/day late fee for all past due balances in excess of 30 days. All patients are financially responsible for the full amount of all services deemed "non-covered" by your insurance carrier. Secondary insurances are billed as a courtesy. If a secondary carrier does not pay for any reason the patient is financially responsible for the full amount of unpaid services. This bill is for professional services. For billing questions or to make a payment, please call (818)718-2301. Thank you for allowing us to serve you.

Medicare: We participate with Medicare. We will bill Medicare as your primary insurer; we will also bill your supplemental insurance provider. **Medicaid:** WE ARE NOT CONTRACTED WITH THIS CARRIER, You will be fully responsible for services provided to you.

Check Returned: It is our office policy to charge a **$50 fee** for checks that are returned due to ***non-sufficient funds***.

Authorization to Release Information: In obtaining payment for services, I authorize my healthcare provider **AGI** to furnish information from my medical record to any company that may be responsible for payment for all or part of my provider charges, including but not limited to: my insurance companies and their representative, and my employer or union if they are involved in processing the claim. I have been provided with a copy of the ***Notice of Privacy Information Practices. For further information regarding disclosure of health information, please refer to the Notice of Privacy Information Practices which has been provided to you and available in our office or on our website:*** www.agimedical.com

If I have been referred by, or are being referred to another healthcare provider, I authorize **AGI** to release my medical information to this provider for continuing care. I also assign **AGI** all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by my insurance provider or not. I also understand that balances outstanding for more than 90 days will be subject to a processing/Collection fee which will exceed the original charge up to 100%.

Please answer the following questions:

Did you sustain an injury at work?	Yes	No	Are you covered under an employer /union policy?	Yes	No
Are your injuries accident related?	Yes	No	Is your spouse/other family member employed?	Yes	No
Are you currently employed?	Yes	No	Do you have a secondary insurance policy?	Yes	No
Have you ever served in the military?	Yes	No	Are you covered under any other health care plan?	Yes	No
I am a new patient to this practice	Yes	No	Have you made any changes to your choice of Medicare options in the last open enrollment period?	Yes	No
Who is responsible for this bill?	**Name**:		**Relationship to Patient**:		

I, or my appointed agent, have read, fully understand, and agree to the above statements. I can request a copy of this policy at any time.
I attest that the information I have given here is correct and true to the best of my knowledge. I understand that I am responsible for keeping the doctor updated with the current information regarding my account.

____ **X**____ ____________

Patient Name (Please print) Patient signature Date

If the patient is under the age of 18 years, or is otherwise unable to sign, complete the following:
Patient is __________ years of age or is unable to sign because: ____

____________________________________ **X**____________________________________ ____________

Patient Name (Please Print) POA / Guardian / Guarantor's Signature Date

Gilbert Simoni, M.D.
555 Marin Street, Suite # 270
Thousand Oaks, CA 91360
Tel: (805)719-0244 Fax: (805)777-1730

HIPAA PRIVACY PRACTICES

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

My signature below constitutes my acknowledgement that I have been advised of the HIPAA privacy rule.

Signature: ____ Date: ____________________

Printed Name: ____

If not signed by Patient, please indicate relationship: ____

Your medical records and health information are confidential and protected under HIPAA. We take the responsibility to secure your medical information seriously. Please advise us with whom we may share your information directly. No information will be given to any person unless they have your expressed authorization below: **PLEASE CHECK AND INDICATE NAME(S):**

Please X box	**Relationship to Patient**	**Name**
	Spouse	
	Parent	
	Guardian	
	Child	
	Partner	
	Other	

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLIES):

Please X box	**Method**	**Please enter the Phone, fax or E-mail**
	Home Phone	( )
	Work Phone	( )
	Cell Phone	( )
	Fax	( )
	E-mail	
	Other	

Preferred Language: □ English □ Spanish □ Other: _________________________

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www.AGImedical.com

ANESTHESIA Notice

To All of our Patients who will have any Out-Patient Procedure(s) by Dr. Simoni:

This letter is just to make you the Consumer aware of a choice that needs to be made before your procedure.

Most Insurance Plans will not consider payment of Diprivan (Propofol) anesthesia administered by an anesthesiologist for "uncomplicated" endoscopic examination. Instead, they will only cover for "local sedation", which is the usage of intravenous sedatives and opiates administered by the Gastroenterologist, without an Anesthesiologist in attendance.

Dr. Simoni's office will NOT initiate or handle any part of Anesthesia Prior Authorization for this service. It is up to the Patient to contact their insurance carrier and be aware of how this service will be handled by your carrier.

The Anesthesiologists, for their part, have offered their services for administration of Diprivan (Propofol) to our patients see below. We do advise for you to please call ahead of time to discuss your responsibility in regards to this service.

Los Robles Hospital: Conejo Los Robles Anesthesiology (805)578-8300
$350.00 single procedure, $550.00 for 2 procedures done the same day. ERCP $ 550.00.

Advanced Digestive Center of Southern California: Acute Care Anesthesia Services
$290.00 single procedure, $400.00 for 2 procedures done the same day.

Conejo Valley Surgical Center : (805)273-5200
$295.00 single procedure, $420.00 for 2 procedures done the same day.

We would recommend that you accept this offer: it is well-worth avoidance of the potential discomfort or pain and numerous other problems associated with "local sedation".

Upon your arrival at the Surgical Center: Please make the receptionist aware of your choice. The cash discount is only good on the day of your procedure(s); you will be expected to pay on that day. **For all questions related to the Anesthesia fee please call the facility where the service will be provided prior to your appointment date.**

I ____ have read and understand that this does not
PRINT PATIENT NAME
make Advanced Gastroenterology, Inc. responsible for the billing processed by the Anesthesiologist. This is just making me aware of a choice I need to make before my procedure. All billing questions regarding Anesthesia must be directed to the Anesthesiologist who will provide the service(s).

Patient Signature: ____ Date: ______________

ADVANCED GI

Patient Health History

Last Name: ______________________________ **First Name:** ___________________________ MI: ____ **Date:** _____________

Main reason for visit: ____

Current Medications: ☐ None

Name / Dose / Frequency: ____________________________ |__________________________ |________________________

Name / Dose / Frequency: ____________________________ |__________________________ |________________________

Name / Dose / Frequency: ____________________________ |__________________________ |________________________

Name / Dose / Frequency: ____________________________ |__________________________ |________________________

Name / Dose / Frequency: ____________________________ |__________________________ |________________________

Name / Dose / Frequency: ____________________________ |__________________________ |________________________

Past or Present Medical Conditions: ☐ None

Gastrointestinal: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Jaundice ☐ Cirrhosis ☐ Liver disease ☐ Peptic ulcer disease

☐ H. Pylori ☐ Lactose intolerance ☐ GERD / Heartburn ☐ Pancreatitis ☐ Gallstones ☐ Diverticulitis

Cardiovascular: ☐ High blood pressure ☐ High cholesterol ☐ High triglycerides ☐ History of heart attack/angina

☐ Congestive heart failure ☐ Atrial fibrillation ☐ Other heart rhythm disturbance

Respiratory/Lung: ☐ Chronic bronchitis ☐ Emphysema ☐ Asthma ☐ Sleep apnea ☐ Pulmonary embolism ☐ Other _______

Neurology: ☐ Migraine headaches ☐ Stroke ☐ T.I.A . ☐ Seizure

Endocrine: ☐ Osteoporosis ☐ Osteopenia ☐ Diabetes ☐ Hypothyroid ☐ Hyperthyroidism

Genitourinary: ☐ Kidney stone ☐ Kidney failure ☐ Prostate enlargement ☐ Other ______________________

Eye: ☐ Glaucoma ☐ Cataracts ☐ Conjunctivitis ☐ Other ____________________________________

Rheumatology: ☐ Arthritis ☐ Lupus ☐ Rheumatoid arthritis ☐ Sjogrens ☐ Scleroderma ☐ Other _____________________

Psychology: ☐ Anxiety ☐ Depression ☐ Panic attacks ☐ Other ____

Hematology: ☐ Anemia ☐ Blood disorder ☐ History of leg clots (DVT) ☐ Other _____________________________________

Oncology: ☐ Breast cancer ☐ Colon cancer ☐ Prostate cancer ☐ Ovarian cancer ☐ Pancreatic cancer ☐ Lung cancer

Allergies:

☐ No known drug allergies ☐ Iodine ☐ Latex ☐ Penicillin ☐ Codeine ☐ Sulfa (sulfonamides)

☐ Other : ____

Previous Surgeries / Procedures: ☐ None

☐ Colonoscopy Date: _______________findings: _________________________________ GI doctor ___________________

☐ EGD Date: _______________ findings: _________________________________ GI doctor ___________________

☐ Appendectomy ☐ Gallbladder ☐ Hernia Repair _____________ ☐ C-section # ____ ☐ Tubal ligation ☐ Hysterectomy

☐ Ovaries ☐ Tonsillectomy ☐ Laparoscopy ☐ Gastric bypass ☐ Gastric banding (Lap Band) ☐ TIF

☐ Nissen Fudoplication ☐ Coronary artery bypass ☐ Heart valve replacement ☐ Pacemaker ☐ Defibrillator

☐ Other abdominal Surgery _______________________________ ☐ Other _______________________________________

Past Hospitalization: **Date:** __________ **Reason:** ___________________ **Date:** __________ **Reason:** __________________

Family Medical History:

□ No knowledge of family history / Adopted □ No family history of Colon cancer □ IBD (Ulcerative Colitis or Crohn's)

F=Father **M=**Mother **B=**Brother **S=**Sister **GF (M/P)=**Grandfather **GM (M/P)=**Grandmother **Please indicate if (M) Maternal or (P) Paternal)**

Colon Cancer □ Relation: _________ Age: _____ Colon Polyp □ Relation: _________ Age: _____

Esophageal Cancer □ Relation: _________ Age: ____ Barrett's Esophagus: □ Relation: _________ Age: _____

Stomach Cancer □ Relation: _________ Age: _____ Pancreatic Cancer □ Relation: _________ Age: _____

Peptic Ulcer Disease □ Relation: _________ Age: _____ Gallbladder Disease □ Relation: _________ Age: _____

Gallstones □ Relation: _________ Age: _____ Pancreatitis □ Relation: _________ Age: _____

Ulcerative Colitis □ Relation: _________ Age: _____ Crohn's Disease (chronic) □ Relation: _________ Age: _____

Celiac Disease □ Relation: _________ Age: _____ Rheumatoid arthritis □ Relation: _________ Age: _____

Lupus □ Relation: _________ Age: _____ Cirrhosis □ Relation: _________ Age: _____

Liver Disease □ Relation: _________ Age: _____ Hemochromatosis □ Relation: _________ Age: _____

Ovarian Cancer □ Relation: _________ Age: _____ Uterine Cancer □ Relation: _________ Age: _____

Prostate Cancer □ Relation: _________ Age: _____ Bladder Cancer □ Relation: _________ Age: _____

Social History:

Tobacco/smoking status: □ Current every day smoker □ Former smoker □ Never smoker □ Unknown if ever smoked

Alcohol: □ Never uses alcohol □ Social/Occasional □ Daily use □ Heavy : # of drinks per day __________________________

Caffeine: □ Never uses □ Occasional use □ Daily Type / Quantity / Frequency: ______________________________________

Exercise: □ None □ Daily □ a couple of times a week □ once a week □ unable due to health condition

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Living with Significant other

Current Employment: □ Employed □ Unemployed □ Self-Employed □ Retired **Occupation**: ___________________________

Do you smoke Marijuana? □ Yes □ No Frequency: ____

Drug Use: □ None Type / Quantity / Frequency: ____

Immunizations: □ None □ Flu When:____________ □ Pneumonia When: ___________ □ Other __________________
□ Hepatitis A When: ___________ □ Hepatitis B When: ___________

Review of Symptoms:

General/Constitutional: □ Chills □ Fatigue □ Fever □ Weight loss

Head/Ears/Eyes/Throat: □ Hoarseness/voice changes □ Oral Ulcers □ Headache □ Blurred vision □ Eye redness

□ Sinusitis □ Nose bleeds □ Ringing in ears/tinnitus □ Sore Throat

Endocrine: □ Excessive thirst □Heat intolerance □ Thyroid problems

Respiratory: □ Breathing problems □ Chronic cough □ Hemoptysis (Coughing blood) □ Wheezing

Cardiovascular: □ Chest pain □ Claudication (Leg Cramps with exercise) □ Palpitations □ Swelling in Hands/feet

Gastrointestinal: □ Gas □ Bloating □ Black stool □ Painful swallowing (Odynophagia) □ Fill up quickly at meals (Early Satiety)

□ Loss of control of bowel movements (incontinence) □ Abdominal pain □ Blood in stool □ Constipation □ Diarrhea

□ Difficulty swallowing □ Heartburn □ Hematemesis (vomiting Blood) □ Nausea □ Rectal bleeding □ Vomiting

Hematologic/lymphatic: □ Anemia □ Easy bruising □ Swollen glands (enlarged lymph nodes)

Genitourinary: □ Blood in urine □ frequent urination □ Urinary incontinence □ Painful urination □ Excessive urination at night

Musculoskeletal: □ Back pain □ Joint stiffness □ Muscle cramps □ Painful joints

Skin: □ Bruising □ Itching □ Rash

Neurological: □ Numbness □ Trouble walking (use of cane/walker) □ Weakness in extremities

Psychiatric: □ Depression □ Difficulty sleeping (Insomnia) □ Nervousness □ Suicidal thoughts