

New Registration Updated Registration Marital Status: Married Single Divorced Widowed
 Name (First, MI, Last): _____ Date of Birth: _____ Gender Male Female
 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 Other _____ 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 Contact "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: _____



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. "As a courtesy, AGI staff will verify your insurance benefits, however, it is the patient's responsibility to ensure that your policy is in fact IN-NETWORK with Advanced Gastroenterology, Inc. at the time the medical services are rendered". Please see the office Disclaimer regarding insurance carrier(s) and benefits.

Statements: Payment is due upon receipt. AGI (Advanced Gastroenterology, Inc.) reserves the right to charge a \$25.00 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 (805)285-3415. 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 \$30 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 may be subject to a processing/Collection fee.

I have read and understand Office Anesthesia Notice: _____ Patient Initials

I have read and understand Office Financial Policy: _____ Patient Initials

I have read and understand Office Insurance Disclaimer Policy: _____ Patient Initials

Please answer the following questions:

Table with 6 columns: Question, Yes, No, Question, Yes, No. Rows include: Did you sustain an injury at work?, Are your injuries accident related?, Are you currently employed?, Have you ever served in the military?, I am a new patient to this practice, Are you covered under an employer /union policy?, Is your spouse/other family member employed?, Do you have a secondary insurance policy?, Are you covered under any other health care plan?, Have you made any changes to your choice of Medicare options in the last open enrollment period?

Advance Directive Please check box [] Do Not Intubate [] Do Not Resuscitate [] Not Interested

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.

Patient Name (Please print) X _____ 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: _____

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



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 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	PLEASE CHECK AND INDICATE NAME(S)	Contact Phone Number
	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	

Please X box	I WISH TO RECEIVE MY ACCOUNT STATEMENTS AND APPOINTMENT REMINDERS VIA E-MAIL AND/OR PATIENT PORTAL
	YES
	NO
Preferred Language:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:

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 the insurance 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 with your insurance carrier.

Los Robles Hospital: Conejo Los Robles Anesthesiology (805)578-8300
\$350.00 single procedure, \$500.00 for 2 procedures done the same day. ERCP \$ 550.00.

Advanced Digestive Center of Southern California:
\$300.00 single procedure, \$450.00 for 2 procedures done the same day.
CRNA-LA, Inc. EGD \$425 Colonoscopy \$350 EGD & Colonoscopy (same day) \$700

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".

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.**

This does not make Advanced Gastroenterology, Inc. responsible for the billing processed by the Anesthesiologist/CRNA. This is just making the patient aware of a choice they need to make before their procedure. All billing questions regarding Anesthesia must be directed to the Anesthesiologist who will provide the service(s).

Patient Health History

Last Name: _____ First Name: _____ MI: _____ Date: _____

Height: ___' ___" Main reason for visit: _____

Current Medications: None (Include any vitamins or supplements)

Name / Dose / Frequency: _____ | _____ | _____

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 __ Jaundice Cirrhosis Liver disease Peptic ulcer disease H. Pylori Lactose Intolerance
 GERD/Heartburn Pancreatitis Gallstones Diverticulitis other _____

Cardiovascular: High blood pressure High cholesterol High triglycerides History of heart attack other _____

Respiratory/Lung: chronic bronchitis Asthma Sleep apnea Other _____

Neurology: Migraine headaches Stroke T.I.A. Seizure other _____

Endocrine: Osteoporosis Osteopenia Diabetes Hypothyroid Hyperthyroidism other _____

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 Pancreatic cancer Other _____

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 (Year____) Gallbladder (Year____) Hernia Repair _____ C-section # _____

Hysterectomy Laparoscopy Gastric bypass Gastric banding (Lap Band) TIF Nissen Fundoplication

Coronary artery bypass Heart valve replacement Pacemaker Defibrillator

Other abdominal Surgery _____ Other surgeries not listed _____

Past Hospitalization: Date: _____ Reason: _____ Date: _____ Reason: _____

Past Hospitalization: Date: _____ Reason: _____ Date: _____ Reason: _____

Family Medical History:

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

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

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 (year: _____) Never smoker Unknown if ever smoked

Drug Use None Type / Quantity / Frequency: _____

Alcohol never uses alcohol Social/Occasional daily use Heavy # of drinks per day _____

Caffeine never uses Occasional use Daily Type / Quantity / Frequency: _____

Do you smoke Marijuana? Yes No 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: _____

Immunizations:

NONE I don't do any Vaccinations Flu Date _____ Pneumococcal Date _____

Tetanus Date _____ Hepatitis A Date _____ Hepatitis B Date _____ Herpes Zoster (Shingles) Date _____

Review of Symptoms:

General/Constitutional: Chills Fatigue Fever Weight loss

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

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: Bloody 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

• Do you have little interest or pleasure in doing things? Yes No

• Are you Feeling down, depressed, or hopeless? Yes No

Dear Advanced Gastroenterology Patients:

As of May 1st 2019, our staff will no longer make calls to patients for labs, imaging, pathology, or any other results. The results can be either sent via patient portal or via secure e-mail or fax to patients. For interpretation and discussion patients have to come in and discuss results in person with the doctor or Nurse Practitioner.

Calls will be made only for emergencies or serious results that need immediate action from the physician or patient's part.

We also do not pre-authorize any medications, unless it is absolutely needed for a significant chronic condition on select instances per physician or Nurse Practitioner's discretion (see below)*.

No authorizations will be made for imaging studies; it is the responsibility of the imaging center and patient to request from the Insurance Company.

Patients are more than welcome to call their insurance and try to get authorizations forms, fill them out and send to us to sign and send to their insurance which will cost \$25/form.

*There will be a charge for every authorization initiated by our staff as follows:

- Medications: \$150.00/authorization per medication
- Imaging or lab studies: \$200.00/authorization per study
- For peer-to-peer discussion for authorization: \$350.00/authorization

INSURANCE DISCLAIMER

PATIENTS PLEASE NOTE.....

It is your responsibility to know your insurance benefits. At the time you become a participating member of your Medical Insurance Company. You are given an insurance membership handbook and ID card. Please look in your handbook for the following information:

- In-Network Provider
- Individual or Family Deductible amounts
- Waiting periods
- Benefits (Plan Maximums; example – if our fee is \$500.00 and insurance maximum contracted/allowable fee is \$400.00, insurance will pay a percentage of \$400.00, not \$500.00
The difference is your responsibility to pay.

You may also call the customer service number on the back of your ID card and request the benefits department. Most insurance companies have a Web site where you can get information on-line. Every policy is individualized; several people may have the same insurance, but each policy will contain different benefits, and will pay different amounts according to their benefit schedule. One employer may have Anthem Blue Cross and may pay more than another employer with Anthem Blue Cross. It all depends on the benefits package you have chosen.

Because of the 2003 HIPAA regulation (Health Insurance Portability and Accountability Act), insurance companies now have disclaimers protecting individual information. This disclaimer also states that a reference number or authorization number for procedures is not a confirmation or guarantee of coverage or benefits. The coverage of benefits depends upon the individual contract terms, conditions, exclusions, and eligibility at the time the services are rendered.

Our office requires a certain percentage (usually 50 – 70 % depending on the procedure, plus deductible) be paid on the day of service. If your insurance pays more than what we estimate, we will refund you or apply the amount to your next visit. If insurance does not pay less than the estimated amount, you will be responsible and billed for the remainder balance.

It is important that you give us complete and accurate insurance information prior to your Office appointment/Exam/procedure(s), and that you keep us informed of any changes. Please do not give us only a phone number and expect us to gather your information. We must have the insured member's address, birth date and employer, as well as a copy of the insurance card at the time of your office visit.

For your convenience, we will file an insurance claim with your insurance company. You may receive a statement from our office before your insurance has paid. These statements are to advise you of the status of your account. If your insurance company has not responded after 30 days, please take the time to call them and inquire on the status of the claim. Often they require additional information from the member, and the claim will not be processed until you provide them this information. Once the insurance payment is received, it will be reflected on your statement. In the event your medical plan determines a procedure to be "not a covered procedure" you will be responsible for the complete charge. Occasionally, your insurance may send a claim payment directly to the insured for service(s) rendered by our office. In this instance you will be responsible for the full amount of that check. If payment is not forthcoming within a reasonable time, the account and all pertinent information are forwarded to an outside collection agency for collection.

Our Billing office will be glad to assist you at any point during our billing cycle (805)-210-5491.