ADVANCED GI INC

PATIENT REGISTRATION FORMS DATE:

☐ 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)210-5491. 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.

Please answer the following questions:

Did you sustain an injury at work?	Yes	No	**A**re you covered under an employer /union policy?	Yes	No
Are your injuries accident related?	Yes	No	**I**s your spouse/other family member employed?	Yes	No
Are you currently employed?	Yes	No	**D**o you have a secondary insurance policy?	Yes	No
Have you ever served in the military?	Yes	No	**A**re you covered under any other health care plan?	Yes	No
I am a new patient to this practice	Yes	No	**H**ave you made any changes to your choice of Medicare options in the last open enrollment period?	Yes	No

Advance Directive	**Please check one box** ☐ Do Not Intubate ☐ Do Not Resuscitate ☐ Not Interested in answering this
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

ADVANCED GI INC
555 Marin Street, Suite # 270
Thousand Oaks, CA 91360
Tel: (805)719-0244 Fax: (805)777-1730

HIPPA PRIVACY PRACTICES

(Health Insurance Portability and Accountability Act)

The HIPPA 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:	□ English □ Spanish □ Other:

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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.
EGD $300 Colonoscopy $350 EGD & Colonoscopy (same day) $450

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".

This 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 make Advanced Gastroenterology, Inc. responsible for the billing processed by the Anesthesia Provider. This is just to make 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: _____

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Office Cancellation Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hour notification are subject to a $ 25.00 fee.
Procedure cancellations require 5 day advance notice, without notification they will be subject to a $ 200.00 cancellation/NO SHOW fee.
Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Ultra Sound Appointment NO Show $50.00 fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (805)210-5491.

Patient Signature: _____ Date: _____

Financial Policy

A current **Insurance card must be presented at the time of your office visit.** If Advance Gastroenterology, Inc./Dr. Simoni are Out of Network with your insurance carrier the billing department will submit an out of Network Claims with your insurance company. Out of Network patients: Payment in full is due at the time of service.

Payment of co-pays, estimated percentages, deductibles, non-covered services and patient balances is expected at the time of service. Please inform us if you need to make payment arrangements.

We charge a fee for the following items:

- Copy of records/billing — $25 up to 25 pages, all additional pages $0.25/page
- Filling out Work disability forms/FMLA, etc. — $35.00 (TIF surgery related ONLY)
- Copy of Procedure report (on a CD) — $15.00
- **On-line Patient Portal messages and other means of communication requiring** doctor's response may be charged**,** (this service is not covered by your insurance)**.** — $25 – $100 each (Per Occurrence)
- Medication Authorization: $150.00/authorization per medication
- Imaging or lab studies Authorization: $200.00/authorization per study
- For peer-to-peer discussion for authorization: $350.00/authorization

We hope this will help your understanding of our financial policy and assist you in meeting any financial obligation in a timely manner. Please ask our staff for assistance should you have any questions about our policy.

Patient Signature: _____ Date: _____

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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

Patient Signature: _____ Date: _____

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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 pays 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.

Patient Signature: _____ Date: _____

ADVANCED GI INC

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_____

Please note Reactions: _____

Previous Surgeries / Procedures: □ None

□ Colonoscopy Date: _____findings: _____ GI doctor _____

□ EGD Date: _____ findings: _____ GI doctor _____

□ Appendectomy (Year_____) □ Gallbladder (Year_____) □ Hernia Repair _____ □ C-section # _____

□ Hysterectomy (Year_____) □ Laparoscopy □ Gastric bypass(Year_____) □ Gastric banding (Lap Band) (Year_____)

□ 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: _____
Esophageal Cancer □ Relation: _____ Age: ____
Stomach Cancer □ Relation: _____ Age: _____
Peptic Ulcer Disease □ Relation: _____ Age: _____
Gallstones □ Relation: _____ Age: _____
Ulcerative Colitis □ Relation: _____ Age: _____
Celiac Disease □ Relation: _____ Age: _____
Lupus □ Relation: _____ Age: _____
Liver Disease □ Relation: _____ Age: _____
Ovarian Cancer □ Relation: _____ Age: _____
Prostate Cancer □ Relation: _____ Age: _____

Colon Polyp □ Relation: _____ Age: _____
Barrett's Esophagus: □ Relation: _____ Age: _____
Pancreatic Cancer □ Relation: _____ Age: _____
Gallbladder Disease □ Relation: _____ Age: _____
Pancreatitis □ Relation: _____ Age: _____
Crohn's Disease (chronic) □ Relation: _____ Age: _____
Rheumatoid arthritis □ Relation: _____ Age: _____
Cirrhosis □ Relation: _____ Age: _____
Hemochromatosis □ Relation: _____ Age: _____
Uterine 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