GASTROENTEROLOGY ASSOCIATES, P.C.

Karin D. Berg, MD
Kent D. Katz, MD
Phillip T. Krmpotich, MD
Jonathan T. Parrack, DO
Ching "Angela" Wang, MD
Mark Worthington, MD
Kimberley Scott, PA
Caitlin Slaughter, PA
Teri Sweginnis, NP

1600 Willow Creek Rd • Prescott, AZ • 86301
P: 928-792-7701 • F: 928-583-7900

******IT IS YOUR RESPONSIBILITY TO KEEP YOUR PHONE NUMBER AND ADDRESS INFORMATION UPDATED WITH US******

PLEASE PRINT

Legal Name/Preferred Name_____

Date of Birth_____**SS#**_____

Mailing Address/Street Address_____

City_____**State**_____**Zip**_____

CORRESPONDENCE FROM OUR OFFICE IS MAILED IN A SEALED ENVELOPE

If other than your home address, please print the address of where you would like your billing statements and/or correspondence to be sent:_____

_____

Home Phone _____**Cell Phone:**_____

May we leave confidential messages (appointment reminders, test results, etc.) on your home answering machine or voice-mail? **□ YES** **□ NO**

Other than your home phone, where do you want to receive calls about your appointments, lab and x-ray results or other health care information? Phone number: _____

May we leave a message? **□ YES** **□ NO**

Place of Employment_____ **Work Phone**_____

May we leave confidential messages at your place of employment? **□ YES** **□ NO**

Spouse's Name_____ **Date of Birth** _____**Spouse's SS#**_____

Spouse's Employer_____ **Spouse's Employer Phone Number**_____

***If the patient is a minor child*: Parent/Guardian's name**_____

Parent/Guardian's Date of Birth _____ **Parent/Guardian's SS#**_____

Referring doctor_____ **Primary Care Physician**_____

and any other doctors you want to receive a copy of your records:

_____

Have you seen any of our physicians in the last three years? Y__ N__

Information about my general medical condition and diagnosis as well as treatment and payment information may be released to, [list name(s) and phone number(s)]: (example: spouse, siblings, parents)

_____

ONLY IN AN EMERGENCY, please notify, [list name(s) and phone number(s)]:

_____

Person financially responsible_____

Nearest relative not living with you_____

Primary Insurance Company _____ **Policyholder's Name**_____

Complete Claim Address & Telephone Number_____

Policyholder's Date of Birth_____ **Policyholder's SS#**_____

Patient's relationship to the policyholder_____ **Policy/ID #** _____

Secondary Insurance Company _____ **Policyholder's Name**_____

Complete Claim Address & Telephone Number_____

Policyholder's Date of Birth_____ **Policyholder's SS#**_____

Patient's relationship to the policyholder_____ **Policy/ID #** _____

GASTROENTEROLOGY ASSOCIATES, P.C.

Assignment of Benefits. **I hereby assign, transfer and set over to Gastroenterology Associates PC all of my rights, title and interest to my medical reimbursement benefits under the insurance policy I have named above for professional services provided by, Kent D. Katz, MD/Phillip T. Krmpotich, MD/Jonathan T. Parrack, DO/ Ching "Angela" Wang, MD/Mark Worthington, MD in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.**

Authorization to release information **I hereby authorize Kent D. Katz, MD/Phillip T. Krmpotich, MD/ Jonathan T. Parrack, DO/Ching "Angela" Wang, MD/Mark Worthington, MD to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.**

Medicare-Medicaid **I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.**

Patient Name Printed_____**Date**_____

Patient/Parent/Guardian/*POA Signature_____

(*POA/Legal Guardian documentation must be included)

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FINANCIAL POLICIES

The professional services provided by this practice are for your benefit. All fees charged by this practice are your responsibility. For your convenience Gastroenterology Associates, P.C. accepts Cash, Checks, Money Orders, Visa, MasterCard & Discover Card.

Insurance

Gastroenterology Associates, P.C. will bill your insurance as a courtesy; however, payment and/or payment arrangements are expected at the time service is rendered. After 60 days from the date of service, the account will be treated as a self-pay account and you will be required to submit payment in full or make acceptable payments. We will pre-authorize all procedures with your insurance company. If for some reason your procedure date is changed, please contact our billing office so we may notify your insurance company of the change whatever the reason. Failure to do so may alter your reimbursement with a denial or loss, making it your financial responsibility. You have authorized the assignment of your insurance benefits to this office for services. Professional care is provided to you, our patient, not to an insurance company. Thus, the insurance company is ultimately responsible to you, the patient, and you are responsible to the doctor. In order for us to file your insurance, we need to be provided with COMPLETE AND ACCURATE insurance information to avoid delays in payment (i.e. name, address, group, etc. of your primary and secondary insurance). Failure to provide us with correct information could possibly result in you being responsible for your account. You are responsible for all fees not covered by your insurance company including, deductibles, co-pay and reasonable and customary fee differences. Our office cannot accept responsibility for negotiating a settlement on a disputed claim. If you dispute the amount of payment made by your insurance company, you should contact your insurance carrier, your human resources department or your agent directly.

Payment

All payment arrangements should be made at the time or before service is rendered. Should it be necessary to make payment arrangements the following guidelines will be used, a minimum payment should be 10% of the original balance or $50.00 whichever is greater. Should you need assistance in payment of your medical care, please let us know immediately.

The services provided by our physicians are the professional fee. For procedure related services there would be other charges, ie. facility fee, possible pathology charges, anesthesiology or other fees not charged by this practice.

Gastroenterology Associates, P.C. cannot be responsible for your bill with other agencies, i.e. labs, pathology, etc. Any problems with payment of fees other than Gastroenterology Associates, P.C. are the patient's responsibility.

Unpaid Accounts

Patients with unpaid delinquent accounts or accounts which have been written off to bad debt or collection may be denied treatment if not medically necessary.

Patient/Parent/Guardian/POA Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information. Your information may be stored electronically and if so it is subject to electronic disclosure.

How We Use & Disclose Your Patient Information

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures

Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Others Uses and Disclosures

We may be required or permitted to use or disclose the information even without your permission as described below:

Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.

Law Enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.

Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and donation agencies.

Serious threat to health and safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell you health information, unless you have signed an authorization.

Individual Rights

You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.

□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.

□ You have the right to request that we amend your information.

□ You may request a list of disclosures of information about you for reasons other than treatment, payment or health care operations and except for other exceptions.

□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices

We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person(s) listed below.

Complaints

If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send written complaint to the U.S. Department of Health and Human Services. The person(s) listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person(s)

If you have any questions, requests, or complaints, please contact:

Gastroenterology Associates, P.C.
Jon Ross, Office Manager

I, _____
Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____
patient/parent/guardian/POA

If not signed, reason why acknowledgment was not obtained: _____

Staff Witness seeking acknowledgment

_____ Date: _____

Effective Date: 09/01/2013

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PATIENT INTERVIEW FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____

EMAIL

Please check one as your preferred email for communications
☐ Personal: _____ □ Work: _____

RACE

☐ White/Caucasian ☐ Native Hawaiian/Other Pacific Islander
☐ Black/African American ☐ American Indian/Alaska Native
☐ Asian ☐ Unknown ☐ Patient declines to provide information

ETHNICITY-Please check one of the following IN ADDITION to the above

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

LANGUAGES SPOKEN

Primary language spoken**:** ☐ English ☐ Spanish ☐
Other_____

GENDER

☐ Male ☐ Female ☐ Other

SOCIAL HISTORY

Occupation: _____ Number of Children: _____

MARITAL STATUS

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

ALCOHOL

☐ Yes ☐ No (none)---If yes, date last used: _____

Consumption	*Number*
☐ Never	
☐ Rarely	_____
☐ Daily	_____
☐ 2 days or less/week	_____
☐ More than 2 days/week	_____

TOBACCO

Smoking Status
☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker
☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker

☐ Unknown if ever smoked ☐ Vapor/E-Cigarettes ☐ Never smoker

TOBACCO (continued)

Type	*Started*	*Quit*	*Quantity*	*Frequency*
☐ Cigarettes				Cigarettes/day
☐ Cigar				Cigars/day
☐ Chewing Tobacco				Times/day
☐ Pipe				Times/day
☐ Vapor/E-Cigarettes				Times/day

DRUG USE

☐ Yes ☐ No (none)

Type	*Number*
☐ I have never used recreational drugs	
☐ I have used recreational drugs in the past	
☐ I am currently using recreational drugs	
☐ I have been treated for substance abuse	

PHARMACY INFORMATION

Local Pharmacy: _____

Mail Order Pharmacy: _____

May we import/obtain your medication history from your pharmacy(s)?: ☐ Yes ☐ No

ALLERGIES

☐ Patient has no known allergies ☐ Patient has no known drug allergies

Have you ever had a reaction to any type of anesthesia? ☐ Yes ☐ No If yes, which type _____

Please list allergies (medications and environmental) and your reaction. If additional space is required please provide a list.

_____

_____

CURRENT MEDICATION

☐ None

Please list current medications and dosages including any over the counter medications, i.e. vitamins, herbs, aspirin, pain medication. If additional space is required please provide a list.

_____

_____

DIAGNOSTIC STUDIES/TESTS

Have you had any of the following? Please check all that apply.

☐ None ☐ Flex Sig When: _____

☐ EGD When: _____ ☐ Colonoscopy When: _____

☐ ERCP When:_____ ☐ Liver Biopsy When: _____

PAST OR PRESENT MEDICAL CONDITIONS

☐ None

☐ Colon polyps ☐ Ovarian cancer ☐ Anemia ☐ Heart attack/angina

☐ Colon cancer ☐ Prostate cancer ☐ Blood clot/DVT/PE ☐ CHF

☐ Lung cancer ☐ Other Cancer_____ ☐ Bleeding ulcer ☐ Stroke

☐ Breast cancer ☐ Skin cancer ☐ Bleeding disorder ☐ High blood pressure

☐ Liver cancer ☐ Esophageal cancer ☐ History of blood transfusions ☐ Pacemaker/Defibrillator

☐ Kidney Disease ☐ Asthma ☐ Chronic Lung Disease ☐ Emphysema
☐ Kidney stones ☐ Gall stones ☐ Diabetes ☐ Pancreatitis
☐ Reflux ☐ Ulcer ☐ Barrett's Esophagus ☐ Celiac disease

PAST OR PRESENT MEDICAL CONDITIONS (continued)

☐ Liver disease ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
☐ Anxiety disorder ☐ Depression ☐ Obstructive Sleep Apnea ☐ Hypothyroidism
☐ High Cholesterol ☐ Bleeding Disorder (specify) _____ ☐ Other: _____

PREVIOUS PROCEDURES/SURGERIES

☐ None

☐ Appendectomy When_____ ☐ C-Section When_____ ☐ Cardiac Bypass When_____ ☐ Cardiac Surgery When_____ ☐ Hiatal Hernia When_____
☐ Colon Resection When_____ ☐ Prostate When_____ ☐ Joint Replacement When_____ ☐ Hysterectomy When_____
☐ Cholecystectomy/Gallbladder When_____ ☐ Obesity Surgery When_____ ☐ Other_____ When_____

FAMILY MEDICAL HISTORY

☐ I am adopted and do not know my family history

Do you have a family history of:

Celiac Disease ☐ Yes ☐ No
Colon Cancer ☐ Yes ☐ No
Colon Polyps ☐ Yes ☐ No
Crohn's Disease ☐ Yes ☐ No
Inflammatory Bowel Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Ulcerative Colitis ☐ Yes ☐ No

FAMILY HEALTH STATUS

Mother ☐ Healthy & Living ☐ Deceased/At Age_____
Father ☐ Healthy & Living ☐ Deceased/At Age_____
Sister ☐ Healthy & Living ☐ Deceased/At Age_____
Brother ☐ Healthy & Living ☐ Deceased/At Age_____
Daughter ☐ Healthy & Living ☐ Deceased/At Age_____
Son ☐ Healthy & Living ☐ Deceased/At Age_____
Grandmother ☐ Healthy & Living ☐ Deceased/At Age_____
Grandfather ☐ Healthy & Living ☐ Deceased/At Age_____

Which family member, if any, has been diagnosed with the following:

DIAGNOSIS	**RELATIONSHIP**
Alcoholism	
Barrett's Esophagus	
Brain Cancer	
Breast Cancer	
Celiac Disease	
Colitis	
Colon Cancer	
Colon Polyps	
Crohn's Disease	
Esophageal Cancer	
Gastric Cancer	
Kidney Cancer	
Liver Cancer	
Liver Disease/Cirrhosis	

Ovarian/Uterine/Endometrial Cancer	
Pancreatic Cancer	
Stomach Cancer	
Tendency of Bleeding	
Ulcer Disease	
Ulcerative Colitis	