DESERT RIDGE GASTROENTEROLOGY

Patient Demographic Information

(Please Print)

SS#______-______-_______ EMAIL______________________________

NAME____
Last First Middle

ADDRESS____

CITY______________________________STATE_______________ZIP_______

BIRTHDATE_____/_____/_____ GENDER: (M / F) / MARITAL STATUS: S/M/W/D
Month Day Year

PRIMARY PHONE # ( )______-__________OTHER # ( )______-_________

EMPLOYER NAME__________________________PHONE#___________________

EMPLOYER ADDRESS____

SPOUSE NAME__________________________________DOB____/____/_________

SPOUSE EMPLOYER________________________PHONE#___________________

EMPLOYER ADDRESS____

PRIMARY CARE PHYSICIAN____

PCP PHONE # ( )_________-__________

PRIMARY INSURANCE

Insurance_____________________________________
Policy #_______________________________________ Group #_________________
Insured's Name____________________________Relation to Patient_________________
Insured's DOB______-______-_______Insured's Employer_________________________
Insured's SSN______-______-_______

SECONDARY INSURANCE

Insurance_______________________________________
Policy #____ Group #________________
Insured's Name_______________________________Relation to Patient______________
Insured's DOB______-______-_______Insured's Employer_________________________
Insured's SSN ______-______-_______

Please provide BOTH insurance cards during your check-in

May we leave messages regarding appointment(s) on your answering machine? Y___ N___

Signature______________________________________Date______-______-______

Patient Name: ______________________________ DOB: ____/____/______

Chief Complaint: ______________________________

History of Present Illness: ______________________________

Drug Allergies: ______________________________

Current Medication: ______________________________

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Asthma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertenson	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Crohn's or Ulcerative Colitis	☐	☐	☐	☐	☐	☐
Stomach Ulcer	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Gall Bladder Dx	☐	☐	☐	☐	☐	☐

Habits

☐ Smoke: Packs Daily ____________
How Long ____________

☐ Exercise Routine: ____________

☐ Contact with blood/bodly fluids at work: ____________

☐ Coffee: Cups Daily ____________
other caffeine ____________

☐ Alcohol: Type ____________
Amount ____________
Frequency ____________
How long ____________

☐ Aspirin use:
Frequency ____________
Amount ____________
Dose ____________

☐ NSAID use:
Drug ____________
Amount ____________
Dose ____________

Hepatitis C risk factors

☐ Drug use (1+ times)
☐ Tattoos
☐ Blood transfution prior to 1992
☐ Contact with blood/bodily fluid
☐ Body Piercing

Immunization (Year last received, if known)

Hepatitis ____________ TB Skin Test ____________

List any conditions you are being treated for: ______________________________

List any previous surgeries you have had: ______________________________

Check (√) symptoms you currently have or have had in the past:

General
☐ Chills
☐ Depression
☐ Dizziness / Fainting
☐ Fatigue
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of sleep
☐ Loss of weight
☐ Numbness
☐ Sweats

Muscle / Joint / Bone Pain, weakness, numbness in:
☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

Genito-Urinary
☐ Blood in urine
☐ Frequent urination
☐ Lack of Bladder control
☐ Painful urination

Gastrointestinal
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Poor Appetite
☐ Diarrhea
☐ Difficulty Swallowing
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal Bleeding
☐ Stomach Pain
☐ Vomiting
☐ Vomiting Blood

Cardiovascular
☐ Chest Pain
☐ High / Low blood pressure
☐ Irregular / Rapid heart beat
☐ Poor circulation
☐ Shortness of breath
☐ Swelling in ankles
☐ Varicose veins

Check (√) conditions you have had in the past:

☐ Anemia ☐ AIDS / HIV
☐ Alcoholism
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleedig Disorder
☐ Cancer
☐ Chemical Dependency
☐ COPD
☐ Colon Polyps
☐ Coronary Artery Dx
☐ Diabetes
☐ Elevated Liver Enzymes
☐ Epilepsy
☐ Esophageal Stricture
☐ Glaucoma
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ Herpes
☐ High Cholesterol
☐ Hypertentension
☐ Kidney Disorder
☐ Liver Disease
☐ Migraine Headaches
☐ Mitral Valve Prolapse
☐ Multiple Sclerosis
☐ Pacemaker
☐ Prostate Problems
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Thyroid Problems
☐ Total Joint Replacement
☐ Tuberculosis
☐ Ulcers
☐ Valvular Heart Dx
☐ Venereal Disease

BRUCE S. SAND, D.O., FACOI
4045 E. BELL ROAD (SUITE 139)
PHOENIX, ARIZONA 85032

FINANCIAL POLICY

Welcome to Desert Ridge Gastroenterology & Liver Disease. We are committed to the delivery of the most comprehensive medical care for our patients. In addition, we would like to take this opportunity to inform you of our office insurance, payment, and billing policies. We bill insurance as a courtesy to our patients. We will accept payment from your insurance company, however, we require that you pay your insurance co-pay, co-insurance, or deductible responsibility prior to receiving your healthcare service(s). In addition, you will be responsible for payment prior to your appointment if our office is not in receipt of your required referral at the time of your visit.

If you fail to provide our office with your secondary and/or tertiary insurance cards during the check-in process and/or we are not a contracted provider, you agree that you will be responsible for all costs for services rendered by a non-participating provider. Payment is due in full within ten (10) business days of the date of your first billing statement. Failure to make payment in full within the foregoing timeframe will result in interest accruing on all unpaid amounts at the rate of 35% per annum, until paid. In the event that legal action is necessary in order to recover any amounts that remain unpaid, the prevailing party in such action will be entitled to an award of reasonable attorneys' fees and costs.

CO-PAYS

Your insurance co-pay is due during the check-in process prior to your rendered healthcare service. We do not bill for co-pays.

DEDUCTIBLE / CO-INSURANCE

If your insurance deductible / co-insurance is not met, full payment will be collected during the check-in process and prior to your rendered healthcare service. If your insurance deductible is met, your coinsurance amount will be collected 2 business days prior to your *scheduled* **Colonoscopy / Endoscopy procedure(s).**

PRIVATE PAY and OUT OF NETWORK

If you have no insurance (or elect not to use your insurance), full payment is due during the check-in process and prior to your rendered healthcare service. If we are out of network you will be responsible for charges not covered by your insurance plan and payment of such charges will be due in full during the check-in process and prior to your rendered healthcare service.

I have read and understand and agree to comply with the terms of this financial policy.

Signature____Date______________________

DESERT RIDGE GASTROENTEROLOGY

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. Review the following patient's rights information and provide your signature and date of consent. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. You have the right to revoke this consent in writing although such a revocation will not be retroactive.

By signing this HIPAA form, I understand that:

1) **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
2) **The practice reserves the right to change the privacy policy as allowed by law.**
3) **The patient has the right to restrict the use of information but the practice does not have to agree to those restrictions.**
4) **The patient has the right to revoke this consent in writing at any time and full disclosures will then cease.**
5) **The practice may condition receipt of treatment upon execution of this consent.**

Please indicate to whom the physician / staff may discuss your healthcare in the event you are *incapacitated.* Additionally, if you have a medical representative acting on your behalf, you will need to provide our office with a copy of your designated Medical Power of Attorney document prior to receiving healthcare services.

____

(Name) **(Patient Relationship)**

May we leave a phone message on your answering machine? **Yes_____ No_____**

May we leave a phone message confirming your appointment? **Yes_____ No_____**

____

Patient Signature of Consent

____

Date

BRUCE S. SAND, D.O., FACOI
4045 E. BELL ROAD (SUITE 139)
PHOENIX, AZ 85032

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
99386, 99387 Evaluation/Consultation 99243, 99244 And Or 99213, 99214, 99215 Follow Up 99203, 99204, 99205 Office Visits 45378, 45380 Colonoscopy 43235, 43239, 43249 EGD	Per Medicare Allowable Benefits	$179, $194 $245, $345 $105, $165, $240 $195, $275, $345 $562, 664 $429, $488, $330

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Services listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☒ **OPTION 1.** I want the **D.** Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**__________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**__________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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