DIGESTIVE HEALTH ASSOCIATES, P.C.
SOUTHWEST ENDOSCOPY CENTER, RLLLP

Please Complete and Bring With You

Full Legal Name _____ Age_____

Birthdate_____ □ Single □ Married □ Separated □ Divorced □ Widowed

If patient is a Minor:
Name of Person Legally Responsible _____

Mailing Address _____

City _____ Zip _____

Home Address if Different than Mailing _____

City_____ Zip_____

Social Security Number _____ Home Phone _____

Patient Employed by _____ Occupation _____

Business Address _____

City_____ Zip_____ Business Phone _____

Name of Spouse _____ Age_____

Spouse Employed by _____ Occupation _____

Business Address _____

City_____ Zip_____ Business Phone _____

Person to Notify in Case of Emergency _____
(who does not live with you)

Relationship to You _____

Phone_____

Family Physician _____

Referring Physician _____

Please be prepared to present your insurance card and photo ID card to the receptionist.

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ , hereby authorize Digestive Health Associates and the Southwest Endoscopy Center to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Digestive Health Associates and the Southwest Endoscopy Center can refuse to treat me. I have been informed that Digestive Health Associates and the Southwest Endoscopy Center has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Digestive Health Associates and the Southwest Endoscopy Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Digestive Health Associates and the Southwest Endoscopy Center took before receiving my revocation.

I understand that Digestive Health Associates and the Southwest Endoscopy Center have reserved the right to change their privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that Digestive Health Associates and the Southwest Endoscopy Center restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Digestive Health Associates and the Southwest Endoscopy Center do not have to agree to such restrictions, but that once such restrictions are agreed to, Digestive Health Associates and the Southwest Endoscopy Center must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative Date
(Form MUST be completed before signing.)

_____

Printed name of patient or patient's representative

_____

Relationship to the patient

DIGESTIVE HEALTH ASSOCIATES, P.C.
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FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and the practice, we have adopted this financial policy. If you have any questions, please do not hesitate to discuss them with our Facility Administrator. We are dedicated to providing the best possible care and service to you, and we regard the understanding of your financial responsibilities as an essential element of your care and treatment.

PRIMARY INSURANCE

We currently have direct arrangements with several insurance companies, including Blue Cross and Blue Shield of Colorado, Rocky Mountain Health Plan, Medicare and Medicaid (Colorado), to accept their allowed amount. We will bill these plans directly, and will require you to pay only the authorized copayment and deductible. **It is the policy of this office to collect the copayment at the time of service.**

We anticipate periodic additions and deletions to our list of contracted plans. Please contact our office directly or check our web site (www.digestivehealth.net) for current information regarding our participation status.

If you have insurance coverage through a plan with whom we do not currently participate, we will collect from you any amounts not paid by your insurance. We will prepare and send your insurance company a claim. The insurance company may send the payment to you or to us. If it is sent to you, full payment on your account balance must be made immediately on receipt of the insurance check. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge.

If your insurance requires a referral from a primary care provider, it is your responsibility to obtain one.

SECONDARY INSURANCE

Our office will submit secondary insurance claims for you.

DISCOUNTS

If you do not have insurance coverage, we can offer you a 20% discount on your bill if you pay in full at the time of service.

SELF PAY

If you do not have insurance coverage, it is our policy to collect payment in full at the time of service. Any payment arrangements must be approved by the billing department. Digestive Health Associates may charge interest on Past Due accounts.

I agree that if I am covered by insurance and if my carrier does not pay in full for services I receive through Digestive Health Associates PC ("DHA"), that I am personally responsible for payment of this balance within 15 days of billing. I understand that if any unpaid portion of my personal balance becomes delinquent that it may begin to accrue interest. In the event my personal balance becomes delinquent and further collection efforts are necessary, I agree to pay all costs and reasonable attorney's fees incurred by DHA in said collection efforts. My signature below represents my understanding and acceptance of this policy. I hereby assign all medical benefits to which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release by DHA of any medical information necessary to process any claim or appeal on my behalf. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient/Responsible Party Date

_____

Printed Name of Patient

DIGESTIVE HEALTH ASSOCIATES, P.C.
SOUTHWEST ENDOSCOPY CENTER, RLLLP

STATEMENT DESCRIBING OUR ROLE IN YOUR CARE

In order for us to provide you with the best care we can, it is important for you to understand our role as specialists. Our practice is limited to **gastroenterology** (diagnosis and treatment of disorders of the esophagus, stomach, intestines and pancreas), **hepatology** (diagnosis and treatment of liver disorders), and **gastrointestinal endoscopy**. Our scope is limited to the evaluation and management of the specific problem for which we are seeing you.

If we are seeing you at your physician's or nonphysician primary care provider's request, we will forward a written report of our findings and recommendations. We may order or perform diagnostic tests, such as endoscopy or x-ray studies, and may write prescriptions for treatments that we recommend. You may obtain the results of tests that we order or perform directly from this office. While we may assume responsibility for a portion of your care, in no instance will we be able to provide for your overall health care needs***. Your primary care physician or provider remains in charge of your case.***

If we are seeing you by referral from another specialist or without referral from another physician, we may order or perform diagnostic tests, such as endoscopy or x-ray studies, and may write prescriptions for treatments that we recommend. We may assume responsibility for the ongoing management of a portion of your overall care limited to the gastrointestinal problem for which we are seeing you. In no instance will we be able to provide for your overall health care needs. ***We strongly urge our patients to have a primary care physician or provider.***

As gastroenterologists, we do not provide basic health care. Routine physical examinations, pelvic examinations and pap smears, breast examinations and cholesterol or cancer screening tests are the responsibility of your primary care physician or provider.

I have read and understand the above statement. I agree to accept these limitations of duty in my care. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatments, tests or examination.

DATE_____SIGNATURE_____

DIGESTIVE HEALTH ASSOCIATES, P.C.
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Name:_____ DOB: _____/_____/____
Age: _____ Visit Date: _____/_____/____

REVIEW OF SYSTEMS CLINIC FORM

Please check any active or recent symptoms.

What Pharmacy do you use?_____

Constitutional
- ❑ weight gain
- ❑ weight loss
- ❑ fatigue
- ❑ fever
- ❑ chills
- ❑ malaise
- ❑ night sweats

Eyes
- ❑ burning
- ❑ dryness
- ❑ itching
- ❑ redness
- ❑ double vision
- ❑ vision loss
- ❑ legally blind

Ears
- ❑ hearing loss
- ❑ pain
- ❑ room spinning
- ❑ ringing
- ❑ discharge

Nose / Sinus
- ❑ nasal congestion
- ❑ nose bleeds
- ❑ runny nose

Throat / Mouth
- ❑ sore throat
- ❑ choking
- ❑ lump in throat
- ❑ hoarseness
- ❑ dental pain
- ❑ mouth sores
- ❑ gum bleeding
- ❑ dentures
  fit well? yes / no

Respiratory
- ❑ shortness of breath
- ❑ cough
- ❑ sputum
- ❑ blood in sputum
- ❑ wheezing
- ❑ TB exposure
- ❑ positive TB test
- ❑ lung pain

Cardiovascular
- ❑ chest pain
- ❑ shortness of breath lying down
- ❑ swelling
- ❑ palpitations
- ❑ fainting

Vascular
- ❑ leg pain with walking
- ❑ pain
- ❑ skin ulcers
- ❑ Raynaud's

Gastrointestinal
- ❑ loss of appetite
- ❑ nausea
- ❑ vomiting
- ❑ vomiting blood
- ❑ diarrhea
- ❑ constipation
- ❑ blood in stool
- ❑ blood on tissue
- ❑ chest pain
- ❑ gas
- ❑ altered bowel habits
- ❑ abdominal pain
- ❑ trouble swallowing
- ❑ pain swallowing
- ❑ indigestion/heartburn
- ❑ jaundice
- ❑ perirectal conditions
- ❑ regurgitation
- ❑ bloating
- ❑ flank pain
- ❑ feeling full right away

Genitourinary
- ❑ frequency
- ❑ hesitancy
- ❑ urgency
- ❑ burning
- ❑ blood in urine
- ❑ increased night time urine
- ❑ incontinence

Male
- ❑ herpes
- ❑ other sexually transmitted disease
- ❑ erectile dysfunction
- ❑ fertility issues
- ❑ decrease in libido

Female
- ❑ post menopausal
- ❑ menses changes
- ❑ irregular periods
- ❑ decreased flow
- ❑ hormone repl therapy
- ❑ use birth control pills
- ❑ history of infertility
- ❑ sexual dysfunction
- ❑ decrease in libido
- ❑ sexually transmitted disease

Metabolic
- ❑ cold intolerance
- ❑ excessive perspiration
- ❑ chronically overweight
- ❑ excessive urination
- ❑ excessive hunger
- ❑ heat intolerance
- ❑ goiter
- ❑ tremors
- ❑ excessive thirst
- ❑ gestational diabetes
- ❑ enlarged breasts

Neurological
- ❑ headache
- ❑ seizures
- ❑ numbness
- ❑ lightheadedness/dizziness
- ❑ incoordination
- ❑ visual disturbance
- ❑ paralysis
- ❑ involuntary movements
- ❑ abnormal sweats
- ❑ trouble tasting
- ❑ trouble smelling
- ❑ trouble chewing

Psychiatric
- ❑ mood swings
- ❑ hallucinations
- ❑ nervous breakdown
- ❑ anxiety
- ❑ depression
- ❑ bipolar
- ❑ confusion/disorientation

sleep disturbance
- ❑ fitful/restless
- ❑ early awakening
- ❑ trouble falling asleep
- ❑ shift in sleep cycle

Dermatological
- ❑ contact allergy
- ❑ rash
- ❑ skin lesion
- ❑ acne
- ❑ itching
- ❑ pigment change
- ❑ easy bruising
- ❑ hair loss
- ❑ nail changes
- ❑ photosensitivity
- ❑ darkening of skin

Musculoskeletal
- ❑ back pain
- ❑ muscle pain
- ❑ spine stiffness
- ❑ joint pain
- ❑ joint stiffness
- ❑ joint swelling
- ❑ muscle weakness
- ❑ muscle cramping

Hematological
- ❑ easy bleeding
- ❑ swollen glands
- ❑ low blood count

Immunological
- ❑ asthma
- ❑ hay fever
- ❑ contact dermatitis
- ❑ hives
- ❑ dander sensitivity
- ❑ Other _____
- ❑ food allergies
  food_____
  reaction_____

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SOUTHWEST ENDOSCOPY CENTER, RLLLP

Name:_____ DOB: ____/_____/_____
Age: _____ Visit date: ____/_____/_____

HEALTH HISTORY CLINIC FORM

Please write down the reason for your visit:_____

Please circle all active or previous gastrointestinal diagnoses:

Reflux Disease Hiatal Hernia Barrett's Stricture Ulcer Helicobacter pylori

Gallbladder stones Bile duct stones Pancreatitis Celiac sprue Diverticulosis Irritable Bowel Syndrome

Crohn Disease Ulcerative colitis Cancer Colon Polyps Hemorrhoids

Hepatitis Cirrhosis Fatty Liver

Do you have blood in your stool or on the toilet tissue? YES NO

Please circle and describe all active or previous problems:

Do you have any problems with your LUNGS or have ASTHMA or SLEEP APNEA? Do you use OXYGEN? YES NO

Do you have OSTEOARTHRITIS (DEJENERATIVE JOINT DISEASE) or RHEUMATOID ARTHRITIS? YES NO

Do you have DIABETES? YES NO What type? When was it diagnosed? How is it controlled? What is your normal blood sugar level?

Do you have HIGH BLOOD PRESSURE? YES NO Have you ever had a HEART ATTACK or STROKE? YES NO

Do you have an IRREGULAR HEARTBEAT? Do you take a BLOOD THINNER? Do you see a CARDIOLOGIST?

Do you have or have you had HEPATITIS, TUBERCULOSIS or HIV INFECTION? YES NO

Do you have any problems with your KIDNEYS? YES NO

Do you have any problems with your LIVER? YES NO

Have you been diagnosed with CANCER of any kind? YES NO When? What surgery did you have? Did you have radiation and/or chemotherapy?

Have you ever been hospitalized or had any surgical procedure? What year?

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Do you have any other conditions that we haven't asked about?

Lifestyle review: *If **yes,** please specify as indicated*

Have you ever smoked? YES NO Packs/day _____ # Years _____ Quit? _____ When? _____
Do you drink alcohol? YES NO # drinks/day _____
Do you consume caffeine? YES NO # servings/day _____ Please circle: coffee tea soda chocolate
Do you eat or drink milk products? YES NO #servings/day _____
Have you ever used recreational or IV drugs? YES NO
Have you ever been abused (physical/sexual)? YES NO
Do you regularly take aspirin/anti-inflammatory products (Motrin, Aleve, Advil, etc) YES NO Specify: _____

Drug Allergies? YES NO: (please note reaction)_____
Latex Allergies? YES NO : (please note type)_____
Are you allergic to I.V. Contrast Dye? YES NO: type?:_____

Please list ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS, VITAMINS, AND SUPPLEMENTS

What medicine?	What is the dosage?	How often do you take it?

Family History:

	Mother	Father	Sister	Brother	Son	Daughter	Grandfather	Grandmother	Other	Additional Info:
Current Age or Age at Death:										
Illness/Condition:										
Alcoholism:										
Colitis/Diarrhea:										
Colon Polyps:										
Colon Cancer:										
Other Cancer:										
Liver Disease:										
Ulcer Disease:										
Liver patients should continue… Autoimmune Disease: Diabetes: Heart Disease: Thyroid disease:										