PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____
Date of Birth: _____ Age: _____ Sex: ❑Male ❑Female
Street Address: _____
Apt #: _____ City: _____ State:_____ ZIP:_____
Mailing Address (if different): _____
Home Phone: _____ Work Phone: _____
Cellular Phone:_____ E-mail:_____
Employer: _____ Occupation: _____
Work Address: _____
City: _____ State _____ ZIP: _____
Social Security #: _____ Driver's License #: _____
Marital Status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
Race: ❑American Indian or Alaska Native ❑Asian ❑ Black or African American
❑Native Hawaiian or other Pacific Islander ❑ White ❑Other Race
Ethnicity: ❑ Hispanic or Latino ❑Non-Hispanic or Non-Latino

INSURANCE INFORMATION

Primary Insurance Co: _____
ID #: _____ Group #: _____ Co-pay Amount: $ _____
Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance Co: _____
ID #: _____ Group #: _____ Co-pay Amount: $ _____
Subscriber Name: Subscriber DOB:

GUARANTOR INFORMATION

Please complete this section if someone other than the patient is guarantor of payment.
Guarantor's Name (❑spouse, ❑parent or ❑guardian): _____
Street Address: _____
Apt #: _____ City: _____ State:_____ ZIP:_____
Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Work Address: _____
City: _____ State _____ ZIP: _____
Social Security #: Driver's License #:

OTHER IMPORTANT INFORMATION

Contacts:
Spouse: Name _____ Cell Phone _____ Work Phone _____
Emergency Contact: Person to contact in an emergency (someone not living with you):
Last Name _____ First Name _____ Relationship _____
Home Phone # _____ Cell Phone #_____
Pharmacy: Name & City _____ Phone _____
Referring MD: _____**Primary Care Physician:** _____
How did you hear about us? ❑Referred by Physician (Name: _____)
❑I am existing Patient ❑Referred by Friend or Family Member (Name:_____)
❑Listed in Insurance Plan Roster ❑Internet : Name of the website: _____
❑Phone Book ❑Other (please specify): _____

Signature of Patient/Guardian:_____ Date: _____

PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.

PRIVACY PRACTICES NOTICE AND ACKNOWLEDGEMENT

Last Name _____ First Name _____ Date of Birth _____

Privacy Notice: This notice describes how your medical information may be used and disclosed for the purposes of treatment, payment, and healthcare operations, and how you can access this information. This explains your rights and our obligations under the law. This notice may be revised from time to time.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This is also available online at www.PacificGastro.com .

Acknowledgement: I acknowledge that I have been provided an opportunity to review and receive the notice of privacy practices.

RELEASE OF INFORMATION

☐ I authorize the release of my protected health information (PHI) to the following individual(s):

- ☐ Spouse: Name _____
- ☐ Child(ren): Name(s) _____
- ☐ Other: Name and relationship _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call: ☐ First preference Phone # _____

☐ Second preference Phone # _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signature of Patient/Guardian _____ Date _____

PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.
FINANCIAL POLICY

PATIENT INFORMATION		
Name:	Date of Birth:	Today's date:

Thank you for choosing us as your health care provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is important. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Regarding Insurance:
As a courtesy our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us correct insurance information. **It is your responsibility to inform us if your insurance has changed at any time during treatment**. Please understand that your bill is ultimately your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full in a timely manner, it will then become your responsibility to pay the balance. We accept Cash, Check, Visa and MasterCard. You will be charged a $25 fee for any returned check. Any account over 90 days old without payment is subject to being sent to a collection agency.

**All co-pays are due at the time of visit. Deductibles are due prior to procedure.

Credit card on file for remaining balance:
We require your credit card information (Visa or MasterCard) for any remaining balance which is not covered by your health insurance. Your signature on file is to permit us to charge your credit card up to $100. For any balance exceeding $100, we will call you for your permission to charge your credit card; or if you wish, you could still pay by cash or check.

Referrals and Pre-authorization:
If your insurance company requires a referral from your primary care physician, you must present this to our staff before being seen. If you do not obtain a referral when your insurance company requires one, you will be required to pay in full for the visit or service. It is your responsibility to obtain a referral.

Missed Appointments and Cancellation Fee:
Due to the amount of time allotted for scheduled endoscopic procedures, we do request at least 3 working days notice for cancellation of any procedures. **It is our policy to charge a $100.00 cancellation fee if given less than 3 working days notice.** The charge for a late cancellation/no show for procedure will be billed directly to you and not to your insurance. Please help us serve you better by keeping scheduled appointments.

Ancillary Services:
Please be aware that there may be a charge involved for ancillary services such as completing disability forms and/or forms related to your care, and drafting letters on your behalf. A $10 copying and handling fee is charged for providing medical records to you.

Patient Balances/Late Fee:
If payment is not received within 30 days of the statement, a $10.00 late fee each month will be applied to your balance until full payment is received.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I authorize Om P. Chaurasia, M. D., Inc. dba Pacific Gastroenterology Medical Associates, Inc. or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the physician.

I have read the Financial Policy in full and I understand and agree to this policy.

_____ _____
Signature of Patient/Guardian Date

PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.
HEALTH QUESTIONNAIRE

PATIENT INFORMATION		
Name:	Date of Birth:	Current Age:
Today's date:	Referring physician:	

Reason of Visit/Chief Complaint:

MEDICAL HISTORY – PAST OR PRESENT ILLNESS				
Gastrointestinal system:				
☐ Acid Reflux/GERD	☐ Peptic ulcer	☐ Helicobacter pylori	☐ Barrett's esophagus	☐ Celiac disease
☐ Ulcerative colitis	☐ Crohn's disease	☐ Diverticulosis of colon	☐ Irritable bowel (IBS)	☐ Hemorrhoids
☐ Colon Polyp	☐ Colon cancer	☐ Esophageal cancer	☐ Stomach cancer	☐ Liver cancer
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ Fatty liver	☐ Cirrhosis of liver
☐ Gall stones	☐ Pancreatitis	☐ Alcoholism	☐ Eating disorder	☐ Lactose intolerance
Other systems:				
☐ High blood pressure	☐ Heart artery disease	☐ Irregular heart rhythm	☐ Heart failure	☐ Heart attack (MI)
☐ Heart murmur	☐ COPD/Emphysema	☐ Asthma	☐ Sleep apnea	☐ Pulmonary embolism
☐ High cholesterol/Lipid	☐ Bleeding disorder	☐ Anticoagulant therapy	☐ Anemia	☐ Deep venous clots
☐ Diabetes mellitus	☐ Pre-diabetes	☐ Hypothyroidism	☐ Kidney disease	☐ Kidney stones
☐ Osteoporosis	☐ Osteopenia	☐ Osteoarthritis	☐ Rheumatoid arthritis	☐ Spine/disc disease
☐ Migraine	☐ Anxiety	☐ Depression	☐ Bipolar disorder	☐ Schizophrenia
☐ Seizures	☐ Stroke	☐ Parkinson's disease	☐ HIV/AIDS	☐ TB/Positive PPD
☐ Basal cell skin cancer	☐Squamous skin cancer	☐ Melanoma	☐ Glaucoma	☐ Gout
List other Illnesses:				

PREVIOUS GASTROINTESTINAL PROCEDURES ☐ No GI Procedures			
Procedure	**Date(s)**	**Procedure**	**Date(s)**
☐ Colonoscopy		☐ Upper GI Endoscopy/EGD	
☐ Sigmoidoscopy		☐ Other	

PREVIOUS SURGERIES ☐ No Surgeries			
Surgery	**Date(s)**	**Surgery**	**Date(s)**
☐ Appendectomy		☐ Gall bladder removal	
☐ Gastric bypass		☐ Laparoscopy	
☐ Colon resection		☐ Exploratory, abdomen	
☐ Hemorrhoid surgery		☐ Hernia repair, groin	
☐ Heart bypass surgery		☐ Heart stent(s)	
☐ Heart pacemaker		☐ AICD/defibrillator	
☐ Artificial heart valve		☐ Tonsillectomy	
☐ Hip Replacement : ☐ Left ☐ Right		☐ Knee replacement: ☐ Left ☐ Right	
☐ Hysterectomy: ☐Partial ☐Complete		☐ Caesarean section	
☐ Tubal ligation		☐ Mastectomy: ☐ Left ☐ Right	
☐ Lasik eye surgery		☐ Cataract: ☐ Left ☐ Right	
List other Surgeries and their dates:			

IMMUNIZATION HISTORY	
☐ Hepatitis B vaccination , when:	☐ Hepatitis A vaccination, when:

SOCIAL HISTORY
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil union ☐ Other
Children: ☐ No ☐ Yes Number: **Occupation:** ☐ Retired ☐ Disabled
Tobacco Smoking: ☐ Never smoked ☐ Quit smoking, When: _____ ☐ Current smoker: ☐ Daily ☐ Someday
Number of cigarettes per day: ☐ 0-5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more
Alcohol: ☐ None ☐ Quit, When: _____ ☐ Current # of drinks on a typical day: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
Frequency: ☐ 4 or more days/week ☐ 2-3 days/week ☐ 2-4 days/month ☐ Monthly or less
Caffeine: ☐ None ☐ Coffee: _____ cups/day ☐ Tea: _____ cups/day ☐ Soda: _____ drinks/day:
Recreational Drug use: ☐ Never ☐ Quit using ☐ Currently using; DRUG: ☐ Marijuana ☐ Cocaine ☐ Other _____
Blood transfusion: ☐ No ☐ Yes, When: **Tattoo:** ☐ No ☐ Yes **Acupuncture:** ☐ No ☐ Yes

Patient Name:	Date of Birth:

FAMILY HISTORY				☐ Unknown ☐ Adopted
Relative	**Colon cancer**	**Ulcerative colitis**	**Crohn's disease**	**Other Disease(s)**
Father	☐	☐	☐	
Mother	☐	☐	☐	
Brother	☐	☐	☐	
Sister	☐	☐	☐	
Son	☐	☐	☐	
Daughter	☐	☐	☐	
Paternal grandmother	☐	☐	☐	
Paternal grandfather	☐	☐	☐	
Maternal grandmother	☐	☐	☐	
Maternal grandfather	☐	☐	☐	
Uncle	☐	☐	☐	
Aunt	☐	☐	☐	
Nephew	☐	☐	☐	
Niece	☐	☐	☐	
No known Family history of: ☐ Colon cancer ☐ Crohn's disease ☐ Ulcerative colitis ☐ Esophageal cancer				
Any comment / relevant Family history:				

REVIEW OF SYSTEMS: Please check appropriate boxes if you **currently** have any of these symptoms.				
General/Constitutional:				
☐ Fever	☐ Tired/fatigue	☐ Loss of appetite	☐ Recent weight loss	☐ Recent weight gain
Gastrointestinal system:				
☐ Abdominal pain	☐ Diarrhea	☐ Constipation	☐ Bowel habit change	☐ Stool caliber change
☐ Rectal bleeding	☐ Black tarry stool	☐ Fecal incontinence	☐ Anal/rectal pain	☐ Anal itch
☐ Heartburn	☐ Acid regurgitation	☐ Excessive burping	☐ Nausea	☐ Vomiting
☐ Difficulty swallowing	☐ Painful swallowing	☐ Vomiting blood	☐ Abdominal bloating	☐ Flatulence/gaseous
Cardiovascular:				
☐ Chest pain	☐ Shortness of breath	☐ Dizziness/fainting	☐ Palpitations	☐ Ankle swelling
Respiratory:				
☐ Cough	☐ Wheezing	☐ Coughing up blood	☐ Sleep apnea	
Eyes/ENT:				
☐ Blurred vision	☐ Loss of vision	☐ Sore throat	☐ Hoarse voice	☐ Nose bleeding
Genitourinary/Kidneys:				
☐ Frequent urination	☐ Blood in urine	☐ Dark urine	☐ Urethral discharge	☐ Impotence
Endocrine:				
☐ Heat intolerance	☐ Cold intolerance	☐ Excessive thirst	☐ Excessive hair loss	
Hematologic/Lymphatic:				
☐ Bleeding gums	☐ Excessive bruising	☐ Prolonged bleeding	☐ Swollen glands/nodes	
Musculoskeletal:				
☐ Joint pain	☐ Joint swelling	☐ Joint stiffness	☐ Lower back pain	☐ Neck pain
Neurological:				
☐ Headache	☐ Fainting	☐ Tingling/numbness	☐ Paralysis of limb(s)	☐ Seizures
Psychiatric:				
☐ Difficulty sleeping	☐ Excessive stress	☐ Panic attacks	☐ Suicidal thoughts	☐ Hallucination
Skin:				
☐ Rash	☐ Itching	☐ Hives	☐ Jaundice	☐ Skin lesions
Female patients only:				
☐ Abnormal menses	☐ Menopause	☐ Oral contraceptive	☐ Currently pregnant	☐ Vaginal bleeding

ADDITIONAL COMMENTS:

Signature of Patient/Guardian

Date

PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.
MEDICATIONS & ALLERGY FORM

PATIENT INFORMATION		
Name:	Date of Birth:	Current Age:
Today's date:	Pharmacy:	

☐ **See Attached Medication List**

PRESCRIPTION MEDICATIONS - CURRENTLY USING ☐ Not taking any prescription medication

Medications	Dose (How much?)	Route (How taken?)	Frequency (How often?)	Indication (What for?)
Example: Nexium	*40 mg capsule*	*Orally*	*Once a day*	*Acid reflux*
Additional comment:				

OVER THE COUNTER (OTC) MEDICATION/SUPPLEMENT - CURRENTLY USING ☐ Not taking any OTC medication

Medications	Dose (How much?)	Route (How taken?)	Frequency (How often?)	Indication (What for?)
Example: Advil	*200 mg tablet*	*Orally*	*As needed*	*Joint pain*
Additional comment:				

DRUG ALLERGY ☐ No known drug allergy

Medications	Type of reaction	Medications	Type of reaction
Example: Penicillin	*Rash*		
☐ Sulfa			
☐ Erythromycin			
☐ Penicillin			
☐ Latex			
☐ Tape			
☐ IV contrast			
☐ Demerol			
☐ Versed			
Additional comment:			

Signature of Patient/Guardian

Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-12)