Desert Valley Gastroenterology

arizona gastrointestinal associates

Raxitkumar Patel, MD

4540 E Baseline Rd Suite 115 Mesa, AZ 85206 Tel (480) 306-6405 Fax (480) 306-6409

Records Request and/or Release

Printed Name: **Date of Birth:**

I hereby authorize Desert Valley Gastroenterology to:

Request and Obtain my medical records for my continuing medical care.

From:_____

From:_____

Release medical records FROM Desert Valley Gastroenterology for the purpose of continuing medical care. *(This will allow the office to disclose my medical records to all providers and facilities participating in my ongoing medical care.)*

To:___ P C P / Referring provider_____

To:_____

I authorize the use and disclosure of my entire medical record in the possession of Desert Valley Gastroenterology. Any further disclosure of medical record information by the recipient(s) is not authorized without specific written consent of the person to whom it pertains. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. Insurance company or Health Care Professional, it may no longer be protected by the federal and state privacy regulations. For the purpose hereof, "Entire Medical Record" shall include ALL confidential and HIV-related information (as defined in A.R.S. section 36-661), confidential Alcohol or drug Abuse related information (as defined in 42 CF section 2.1 ET SEQ), and confidential Mental Health Diagnosis/Treatment information. This authorization may be revoked in writing by the undersigned at any time prior to the release of the information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. I am aware that this authorization shall become effective immediately and shall remain in effect for one year from the day of signature. A copy of this signed authorization is valid as an original.

x Signature of Patient or *Legal Representative:* **Date:**_____

If signed by representative:

__Print name of signing representative:_____

__Give relationship to patient:_____

__ Patient was unable to sign because_____

__ Patient refused to sign.

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Patient Registration Form

Name:_____Date of Birth:_____

Gender:_____

Address:_____Unit/Apt:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone: _____

Ok to leave automated message? ◯yes ◯no Email: _____

Referring Physician:_____ Primary Care Physician:_____

Language:_____ Are you Hispanic/Latino?:_____

Race: ◯American Indian/Native Alaskan ◯Black/African American ◯Asian ◯Native Hawaiian/Pacific Islander

◯White ◯Other_____ ◯Declines to specify

Employer:_____Occupation: _____

◯Full Time ◯Part Time ◯Retired ◯Unemployed

Emergency Contact:_____Relationship:_____ Phone:_____

Authorized individuals –Please authorize any individuals, not including physicians (example: spouse, parent, child), who you would like us to be allowed to release information to regarding your medical care. **We will <u>not</u> speak with anyone who is not authorized.**

◯Same as emergency contact Name: _____Name:_____

<u>Insurance Information</u> ◯copy on file

Primary Insuance: _____Member ID:_____Group#:_____

Subcriber Name (if diffent from patient):_____Date of Birth:_____

Secondary Insuance:_____Member ID:_____Group#:_____

Subcriber Name (if diffent from patient):_____Date of Birth:_____

I assign all medical benefits to Arizona Gastrointestinal Associates and understand that I am financially responsible for all charges whether or not they are paid by my insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediatley. If the account is not paid in full, and prior arrangements have not been made, your account may be referred to a collection agency. If your account is referred to an agency you will be resposible for all collection fees. I hereby authorize the physician to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I certify the above information is true and correct to the best of my knowledge. I understand the HIPAA and privacy policies are available upon request. I have read and understand the information on this form.

Signature:_____ Date:_____

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FINANCIAL POLICY

Thank you for choosing Arizona Gastrointestinal Associates as your health care provider. The following is an explanation of our financial policy, which we require you to read and sign prior to receiving any services.

- Full payment of copays and deductibles are due at time of service. We accept cash, checks and credit cards. There will be a $50.00 service fee charge on returned checks.

- Missed appointments without adequate notice will be charged a $50.00 fee for office visits (24 hour notice) and $150.00 for procedures (48 hour notice).

- We will file medical claims to your health insurance carrier, on your behalf, for services rendered by this office. We will require all information for filing be received at time of service.

- Be advised that verification of eligibility and benefit information obtained from your carrier is **not** a guarantee of payment. Should our claim, in full or partially, be denied by your carrier, you are responsible for **all** charges not covered, and payment in full is expected promptly.

- You, as the insured member, are responsible for knowledge and understanding of your plan's benefit requirements. Many carriers require referrals for certain services. You are responsible for verifying a referral is on file for you visit.

- Your medical records may be copied upon request, with written authorization. Please allow 2 weeks to copy your records. The Arizona Legislature (A.R.S. 12-2295) states that a reasonable fee for copying your records can be charged. **Arizona Gastrointestinal Associates charges $0.50(fifty cents) per page.** This fee will be due prior to release of records. **We will also charge you the actual cost for postage if you have the copies mailed to you.** No postage charge will apply if you pick up your records. There will be no charge for records sent to another physician or healthcare provider involved with your continuity of care.

I certify that I have read and fully understand the financial policies of Arizona Gastrointestinal Associates.

Patient Signature: _____ Date: _____

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Steven Kaiser, MD, FACP, FACG • Priti Sud, MD • Anitha Yadav • Raxitkumar B. Patel, MD, MPH

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PATIENT CODE OF CONDUCT

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Desert Valley Gastroenterology expects visitors, patients, and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

THE FOLLOWING BEHAVIORS ARE PROHIBITED:

- Possession of firearms or any weapon
- Physical assault, arson, or inflicting bodily harm
- Making verbal threats or menacing gestures while in the office or through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Use of derogatory remarks not limited to race, language, or sexuality
- Intentionally damaging equipment or property

THIS OFFICE DOES NOT PRESCRIBE CONTROLLED SUBSTANCES/NARCOTICS
THIS OFFICE DOES NOT COMPLETE FMLA/DISABILITY PAPERWORK

In order to ensure that the privacy of our patients and staff is protected and so as to ensure that the physician-patient relationship remains confidential and private, Desert Valley Gastroenterology does not permit anyone to record, video tape, or photograph our facilities in any way during any visit or appointment with us.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member.

Our practice follows a zero-tolerance policy for aggressive behavior directed by patients/visitors against our staff. Violators are subject to removal from the facility and/or discharge from the practice.

Signature_____ **Date**_____

Patient Health History

Name _____ DOB _____

Allergies:

- ⬭ Patient has no known allergies
- ⬭ Patient has no known drug allergies
- ⬭ Latex
- ⬭ Iodine
- ⬭ Penicillin
- ⬭ Propofol
- ⬭ Demerol
- ⬭ Sulfa
- ⬭ Fentanyl
- ⬭ Eggs
- ⬭ Versed

Other_____

_____

_____

Vaccinations: ⬭**Flu** Date: _____ ⬭**Pneumonia** Date: _____

Past or Present Medical Conditions:

Neurology:

- ⬭ Stroke
- ⬭ Seizures/Epilepsy
- ⬭ Dementia
- ⬭ Parkinson's

Endocrine:

- ⬭ Thyroid Disorder
- ⬭ Diabetes
- ⬭ Osteoporosis
- ⬭ Elevated Cholesterol

Cardiac:

- ⬭ Heart Attack
- ⬭ Atrial Fibrillation
- ⬭ Congestive heart failure
- ⬭ High Blood Pressure

Lungs:

- ⬭ Asthma
- ⬭ COPD
- ⬭ Valley Fever
- ⬭ Sleep Apnea

Gastrointestinal:

- ⬭ Barrett's Esophagus
- ⬭ GERD
- ⬭ Stomach Ulcer
- ⬭ H-Pylori
- ⬭ Colon Polyps
- ⬭ Colon Cancer
- ⬭ Ulcerative Colitis
- ⬭ Crohn's Disease
- ⬭ Diverticulitis
- ⬭ Irritable Bowel Syndrome
- ⬭ Lactose Intolerance
- ⬭ Celiac Disease
- ⬭ Pancreatitis
- ⬭ Cirrhosis
- ⬭ Hepatitis B
- ⬭ Hepatitis C

Urinary:

- ⬭ Enlarged Prostate
- ⬭ Kidney Stones
- ⬭ Kidney Failure

Rheumatology:

- ⬭ Fibromyalgia
- ⬭ Lupus
- ⬭ Rheumatoid Arthritis

Blood:

- ⬭ Anemia
- ⬭ Leukemia
- ⬭ Lymphoma
- ⬭ Bleeding Disorder

Psychiatric:

- ⬭ Anxiety Disorder
- ⬭ Depression
- ⬭ Bipolar Disorder
- ⬭ Schizophrenia

Circulation:

- ⬭ Deep Vein Thrombosis
- ⬭ Pulmonary Embolus
- ⬭ Peripheral Vascular Disease
- ⬭ Carotid Artery Disease

⬭ Cancer: _____

Other condition not listed: _____

Diagnostic Studies/Test

Recent labs? ⬭Sonora Quest ⬭Lab Corp ⬭Other _____

Recent GI imaging? ⬭Simon Med ⬭Az Diagnostic ⬭Banner Img ⬭SMIL ⬭Az Adv Img ⬭Other_____

Hospitalized related to GI within the last 6 months? If so where: _____

⬭ Colonoscopy

When: _____

⬭ Upper Endoscopy (EGD)

When: _____

Previous Procedures & Surgeries

- ⬭ None
- ⬭ Cataract surgery
- ⬭ Defibrillator
- ⬭ C-section
- ⬭ Joint surgery
- ⬭ Tonsillectomy
- ⬭ Appendectomy
- ⬭ Hysterectomy
- ⬭ Bowel surgery
- ⬭ Thyroid surgery
- ⬭ Gallbladder removed
- ⬭ Tubal Ligation
- ⬭ Hemorrhoids
- ⬭ Heart Valve
- ⬭ Abdominal aneurysm
- ⬭ Breast surgery
- ⬭ Coronary Bypass
- ⬭ Pacemaker
- ⬭ Carotid artery
- ⬭ Prostate surgery
- ⬭ Coronary artery stent
- ⬭ Other: _____

Social History

Number of children:_____

Marital Status:

- ⬭ Single
- ⬭ Married
- ⬭ Divorced
- ⬭ Separated
- ⬭ Widowed
- ⬭ Civil Union

Alcohol:

- ⬭ None
- ⬭ Beer
- ⬭ Wine
- ⬭ Hard Liquor

Quantity Number Frequency

Tobacco- smoking status

- ⬭ Current, every day smoker
- ⬭ Current, some day smoker
- ⬭ Former smoker
- ⬭ Never smoked
- ⬭ Unknown

Drug Use (illicit):

- ⬭ None
- ⬭ IV Drugs
- ⬭ Other

Quantity Number Frequency

Caffeine:

- ⬭ None
- ⬭ Coffee
- ⬭ Soda
- ⬭ Energy drinks
- ⬭ Tea

Family Medical History

⬭ No knowledge of family history

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle
Colon Cancer	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Colon Polyps	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Celiac Disease	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Ulcerative Colitis	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Crohn's Disease	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Liver Disease	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
IBD	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Pancreatitis	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

Current Medications: ⬭ **None** ⬭ **List attached** **(including vitamins & supplements)**

Name	Dose	How taken?

I consent to obtaining a history of my medications purchased at pharmacies: ⬭ yes ⬭ no

Review of systems

Constitutional

- ⬭ Fatigue
- ⬭ Fever
- ⬭ Chills
- ⬭ Loss of appetite
- ⬭ Weight gain
- ⬭ Loss of weight (unintentional)

Ear Nose Mouth & Throat

- ⬭ Difficulty swallowing
- ⬭ Hoarseness of voice

Cardiovascular

- ⬭ Chest pain
- ⬭ Palpitations
- ⬭ Ankle swelling

Respiratory

- ⬭ Asthma
- ⬭ Cough
- ⬭ Excessive sputum
- ⬭ Shortness of breath
- ⬭ Wheezing

Gastrointestinal

- ⬭ Abdominal pain
- ⬭ Abdominal distension/bloating
- ⬭ Stomach cramps
- ⬭ Heartburn
- ⬭ Gas
- ⬭ Nausea
- ⬭ Vomiting
- ⬭ Change in bowel habits
- ⬭ Diarrhea
- ⬭ Constipation
- ⬭ Rectal bleeding
- ⬭ Black stools
- ⬭ Rectal Pain
- ⬭ Fecal incontinence
- ⬭ Elevated liver enzymes
- ⬭ Pancreatitis

Genitourinary

- ⬭ Urinary burning
- ⬭ Frequent urination
- ⬭ Urinary incontinence
- ⬭ Urinary hesitancy

Hematologic/Lymphatic

- ⬭ Easy bruising
- ⬭ Prolonged bleeding
- ⬭ anemia

Integumentary

- ⬭ Allergies
- ⬭ Itching
- ⬭ Jaundice
- ⬭ Rashes

Musculoskeletal

- ⬭ Arthritis
- ⬭ Back pain
- ⬭ Muscle weakness
- ⬭ Stiffness

Neurological

- ⬭ Dizziness
- ⬭ Headaches
- ⬭ Numbness or tingling
- ⬭ Seizures

Psychiatric

- ⬭ Anxiety
- ⬭ Panic attacks
- ⬭ Depression
- ⬭ Difficulty sleeping