La Jolla Gastroenterology Medical Group, Inc.

9850 Genesee Ave, Suite 820, La Jolla, CA 92037 (858) 453-5200

My appointment today is with (please fill in): Dr. Paredez

Patient _____ **Birthdate** ___/___/___ **Age**____ **Gender** M◯F◯
(Last Name, First Name, MI)

Address_____ **Marital Status** ____ **S.S. Number**_____
(Mailing Address, including apt #)

City/State/Zip _____ **Home Phone** (____)_____

Work Phone (____) _____ **Cell Phone** (____) _____
Please specify which phone number we may leave confidential messages: Home or Cell

Email _____

Emergency Contact Name/Relationship _____

Phone Number _____

Insurance Carrier Primary _____ Secondary_____

Referred By _____ **Primary Physician** _____

Pharmacy Name and Location: _____

Phone:

Authorization to pay benefits to physician: I hereby authorize payment of medical and/or surgical benefits directly to La Jolla Gastroenterology Medical Group, Inc. for services described on the insurance claim forms. I realize that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due including, but not limited to, deductibles, co-pays, co-insurances, and services not covered under my plan. It is my sole responsibility to know the coverage of benefits for my insurance policy and I agree to remit payment within 30 days of receipt of a statement. All insurance claims will be coded according to guidelines and based on the contents of my medical records. La Jolla Gastroenterology will not be held liable for any services excluded under my insurance policy as coverage and benefits is a contract between my insurance carrier and myself.

Authorization to release information: I hereby authorize the release of any medical or other information necessary to my insurance company to process claims for services rendered and to other physicians involved in my care unless otherwise stated.

HIPAA Policy: I hereby acknowledge receipt of the Notice of Privacy Practices of La Jolla Gastroenterology.

☐ I hereby give my permission for La Jolla Gastroenterology to discuss all information regarding financial matters, assessment, diagnosis, and treatment of my condition, concern, or disease with the following persons. This authorization shall be valid until revoked by myself in writing. **Name and date of birth** of persons authorized to receive HIPAA protected information:

_____ _____

_____ _____

Patient Signature **Date**

La Jolla Gastroenterology Medical Group, Inc.
9850 Genesee Ave., Suite 820, La Jolla CA 92037
Tel. 858-453-5200 – Fax. 858-453-5160

Patient's Name: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** ○M ○F

Height: _____ **Weight:** _____ **Place of Birth:** _____

Where did you live most of your life? _____ **When did you move to San Diego?** _____

Referred by Dr. _____ **or Other:** _____

Primary Physician: _____ **Other Physicians:** _____

Reason for Visit: _____

Medical Allergies (STATE IF NONE): _____

Please list Medical Conditions here:	**Current Medications:** (Give dosage if possible)	**Prior Surgeries:** (List colonoscopy, endoscopy, and x-ray)

FAMILY HEALTH (state the age, health or cause of death in each)

Father: _____ **Mother:** _____

Brothers: _____ **Sisters:** _____

Children: _____

Did relatives have colon cancer ○ **No** ○ **Yes or colon polyps?** ○ **No** ○ **Yes: Who?** _____

SOCIAL HISTORY & HABITS

What is/was your Occupation: _____ **Spouse's Occupation?** _____

Do you exercise? What kind? _____ **How often?** _____

Do you smoke cigarettes? ○**Y**○**N How many and for how long?** _____ **When did you stop?** _____

Do you drink Alcohol? ○**Y**○**N What kind and how much?** _____

Patient Name: _____

REVIEW OF SYSTEMS (PLEASE CIRCLE YES (Y) OR NO (N) FOR EACH ITEM OR QUESTION

Constitutional

Y O N O Fever
Y O N O Chills
Y O N O Appetite Loss
Y O N O Night Sweats
Y O N O Fatigue
Y O N O Recent Weight Gain (_____Lbs)
Y O N O Recent Weight Loss (_____Lbs)

Gastrointestinal

Y O N O Abdominal Pain
Y O N O Anal Itching
Y O N O Belching
Y O N O Bloating
Y O N O Milk/Dairy Intolerance
Y O N O Change in Bowel Habits
Y O N O Constipation
Y O N O Diarrhea
Y O N O Difficulty Swallowing
Y O N O Heartburn
Y O N O Jaundice (Yellow skin)
Y O N O Leakage of Stool
Y O N O Nausea/Vomiting
Y O N O Painful Swallowing
Y O N O Rectal Bleeding
Y O N O Rectal Pain

Heent

Y O N O Hoarseness
Y O N O Chronic Cough
Y O N O Sore Throat
Y O N O Visual Changes
Y O N O Frequent Throat Clearing

Cardiovascular

Y O N O Chest Pain
Y O N O Palpitations
Y O N O Leg Swelling

Respiratory

Y O N O Shortness of Breath
Y O N O Cough
Y O N O Wheezing

Genitourinary

Y O N O Difficulty Urinating
Y O N O Painful Urinating
Y O N O Leakage of Urine

Musculoskeletal

Y O N O Joint Pain
Y O N O Back Pain
Y O N O Joint Swelling

Skin

Y O N O Rashes
Y O N O Itching

Neurological

Y O N O Headaches
Y O N O Dizziness
Y O N O Impaired Memory

Psychosocial Review

Y O N O Do you feel depressed or down?
Y O N O Are you anxious or worry a lot?
Y O N O Have you seen a psychiatrist or counselor?
Y O N O Do you have a lot of stress in your life?
Y O N O Do you have trouble sleeping or getting out of bed?

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La Jolla, CA 92037

Patient Name: _____

Cancellation Policy Fee

We require **3 business day's notice** of cancellation for your scheduled procedure (colonoscopy, EGD, Flex Sig) appointment. When a patient doesn't show for his/her scheduled appointment, another patient loses an opportunity to be seen. Therefore, a fee of $200.00 will be charged per incident. This fee is not covered by insurance carriers or Medicare and will be your responsibility to pay. Your cooperation and consideration are appreciated as we institute this policy to minimize the disruption of work flow as well as accommodating those in need of our services.

By signing below, I understand that I will be responsible for payment of $200.00 should I not provide adequate notice of cancellation.

Insurance claims: I authorize the release of any medical or other information necessary to my insurance company in order to process claims. La Jolla Gastroenterology will submit a claim to my insurance for each appointment (initial consultation, procedures, and follow-up office visits), regardless of the nature of the visit. I will be responsible for the deductibles, co-pays, co-insurances, and non-covered items for services rendered. I am responsible for providing accurate insurance information and will be held liable for all charges should this information not be provided in a timely manner – within one week of services.

La Jolla Gastroenterology does not verify benefits with my insurance company and I understand I am solely responsible for obtaining benefits (including routine/preventative services), plan coverage and exclusions, deductibles, and co-insurances information.

Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

La Jolla Gastroenterology Medical Group

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. You have the right to obtain a paper copy of this Notice upon request.

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.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
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 health 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. 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, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect,
or similar injuries and events.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities. *Health oversight:* We may be required to 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 or court order. *Law enforcement purposes:* Subject to certain restrictions we may disclose information required by law enforcement officials. *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. *Serious threat to health 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.

In any other situation, we will ask for your written authorization before using or disclosing any 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.

Individual Rights
You have the following rights with regard to your health information. Please contact La Jolla Gastroenterology Medical Group to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restriction, but if we do agree, we must abide by those restrictions.
Confidential Communications: 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.
Inspect and Obtain Copies: 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 the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

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.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. La Jolla Gastroenterology Medical Group listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.
If you have any questions, requests, or complaints, please contact:

La Jolla Gastroenterology

9850 Genesee Ave. #820

(858) 453-5200

Effective Date: April 14, 2003

I,_____, (Print)
hereby agree to the above Notice of Privacy Practices and a copy will be provided to me at my request.

Signed:_____Date:_____