Advanced Gastroenterology, P.C.
A division of Arizona Gastrointestinal Associates, PLC
2971 W. Elliot Rd., Ste. 3
Chandler, AZ 85224
Phone 480-733-0500
Fax 480-659-8366

Dear Patient,

For your appointment on _____, please check in no later than _____ with the attached packet. Please **read and complete the packet thoroughly.** Without the completed attached packet, please check in no later than _____.

Please remember to bring the following:

- Photo Identification Card
- Current Insurance Card(s)
- Current Medication List
- List of questions and/or concerns you may have for the provider
- If your insurance requires a referral for you to be seen, please either bring the referral with you or have it faxed to 480-659-8366, ATTN: MEDICAL RECORDS
- Please ask your Primary Care Provider and/or Referring Provider to fax your medical records as soon as possible prior to your appointment to **480-659-8366 ATTN: MEDICAL RECORDS**. Records would include last two office visit notes, last 6 months of labs, any/all diagnostic studies such as ultrasounds, CT scans, etc.
- Please make the office or scheduler aware if you have had any ***hospitalizations in the past year*** that are relevant to your current health issues. The office will need to obtain these records in order to properly address your current gastrointestinal health.

Once the packet has been thoroughly completed and the above items are available, please feel free to call the office for an earlier appointment as we have appointments which open up on a daily basis.

We look forward to participating in your health care.

Sincerely,

The Office of:
Sanjay Ahluwalia, MD

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a division of Arizona Gastrointestinal Associates, PLC

2971 W. Elliot Rd., Ste. 3

Chandler, AZ 85224

www.azgastrohealth.us

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Name: _____ Date of Birth ____/____/____

Medical Release of Information (HIPAA Release Form)

[} I authorize the release of information including the diagnosis, records: examination rendered to me and claims information. This information may be released to:

[ ] Spouse/Partner _____

[ ] Child(ren) *Please include date of birth of child as ID will be asked for

_____

_____

[ ] Other _____

[X] Primary Care Physician/Provider and/or Referring Physician/Provider, per federal HIPAA regulations.

[X] Other Specialists/Doctors/Provider involved in my care, per federal HIPAA regulations.

[X] Records may also be released to Advanced Gastroenterology, P.C./ Dr. Sanjay Ahluwalia, MD

This **release of information** will remain in effect until terminated by me in writing.

Messages

Please call my (choose as many as you prefer: [ ] home [ ] work/business [ ] cell/mobile **WE DO NOT TEXT.**

If **unable** to reach me (please choose **ONE**):

[ ] You may leave a detailed message.

[ ] Please leave a message asking me to return your call.

*****Our practice is not set up to contact or receive contact via email addresses nor texts.**

The best time of day to reach me is (day of week) _____ between (time) _____ and _____.

Signed: _____ Date: _____

Witness: _____ Date: _____

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Advanced Gastroenterology
a division of
arizona gastrointestinal associates

Sanjay Ahluwalia, MD
2971 W Elliot Rd, Suite 3 Chandler AZ 85224 Tel. (480) 733-0500 Fax: 480-659-8366

Patient Information Form

Name (First/MI/Last) _____Title _____ Date of Birth _____Gender___
Marital Status: { }Single { }Married { } Divorced { } Widowed { } Separated { } Other
Address _____ City _____ State _____Zip_____
Preferred Method of Contact: Phone call { } home { } cell Okay to leave message? { } Yes { } No
Home phone _____ Cell _____ Work _____
Email: _____ Social Security # _____

Referring Physician _____Phone_____
Primary Care Physician_____Phone_____

Pharmacy _____Address _____
Phone number _____ Fax number _____

Preferred Language: _____ **Race:** [ ] White [ ] Black or African American [ ]Asian [ ] Unknown
[ ] American Indian/Alaska Native [ ] Native Hawaiian/Other Pacific Islander [ ] Patient declines to specify
Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Patient declines to specify

Responsible Party: [ ] Self [ ]
Other: Name _____ Address _____
City: _____ State: _____ Zip Code: _____Phone: _____

Emergency Contact (This person will be contacted in the case of an emergency ONLY)
Name: _____Relationship: _____ Phone _____

Insurance Information
Primary Insurance _____Relationship to subscriber_____ ID# _____
Group#_____ Network: _____Claims Address _____
Subscriber name _____ Date of Birth _____ Social Security # _____

Secondary Insurance _____Relationship to subscriber_____ ID# _____
Group#_____ Network: _____Claims Address _____
Subscriber name _____ Date of Birth _____ Social Security # _____

PLEASE READ AND INITIAL THE BELOW STATEMENTS

[ ] I assign all medical/surgical benefits to Arizona Gastrointestinal Associates, P.L.C. and understand that I am financially responsible for all charges whether or not they are paid by 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 immediately.

[ ] I hereby authorize the doctor 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 consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and n the office by request.

[ ] I have read and understand the information on this form.

[ ] I confirm that the information I have provided here is correct and true to the best of my knowledge.

_____ _____

SIGNATURE DATE

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Sanjay Ahluwalia, MD

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Patient information form continued:

Allergies

[ ] Patient has no known allergies [ ] Patient has no known drug allergies

[ ] Penicillins [ ] Sulfa (Sulfonamide Antibiotics [ ] Iodine-Iodine Containing [ ] Latex

[ ] Other: _____

Current Medications:

[ ] In lieu of listing my medications, I give permission to Advanced Gastroenterology, P.C. (a division of Arizona Gastrointestinal Associates) to upload my prescriptions.

[ ] None

[ ] List medications, dosages, quantity and frequency: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Advanced Gastroenterology, P.C.

Name: _____

Date: _____

Patient Questionnaire – Anorectal Health

Bowel & Dietary Habits

(Circle either Yes or No for each answer)

1. Do you suffer from Constipation? **Y / N**
2. Do you suffer from Diarrhea **Y / N**
3. Do you have to strain or push hard when having a bowel movement? **Y / N**
4. Time spent on toilet during average bowel movement? _____ Minutes
5. Does any tissue ever come out of your rectum (prolapsed) during a bowel movement? **Y / N**
6. Do you often feel like you're "still not done" after a bowel movement? **Y / N**
7. Are you taking any fiber supplements? **Y / N**
8. On average, do you drink the equivalent of 6-8 glasses of water per day? **Y / N**
9. Are you taking prescription pain pills? **Y / N**

Symptoms (in Rectal Area)

(Check all that apply)

Bleeding Itching Prolapse

Pressure or Swelling Leaking or Soiling Pain Burning

Additional Questions

(Circle either Yes or No for each answer)

1. Are you allergic to latex **Y / N**
2. Are you pregnant? **Y / N**
3. Are you taking any erectile dysfunction medicine for ED, any Viagra for hypertension, Cialis for your prostrate or any nitrates for chest pain? **Y / N**
4. Are you taking any blood thinners or anticoagulation medication (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, etc.)? **Y / N**
5. Have you ever been diagnosed with Crohn's disease, proctitis, portal hypertension or anal/rectal cancer? **Y / N**
6. Are you taking immunosuppressant medication or undergoing radiation treatments? **Y / N**
7. Do you need to take antibiotics before having dental or other procedures? **Y / N**

Additional Comments?

_____

_____

_____

_____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is an explanation of our financial policy, which we require you to read and sign prior to any treatment. If you need additional information or clarification, our front office staff will be glad to address any questions that you may have.

FULL PAYMENT OF ANY COPAYS OR DEDUCTIBLES IS DUE AT THE TIME SERVIDES ARE RENDERED. We accept cash, checks, debit cards, VISA, and MASTERCARD. A $35 service fee will be charged on all returned checks. If a check is returned, all subsequent payments must be made by cash, cashier's check, money order or by debit card, VISA, or MASTERCARD.

Under no circumstances will the Practice waive coinsurance, deductible or any other similar expense and then bill the insurance carrier for these fees.

We charge fees, which are reasonable and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Health Insurance: Every attempt will be made by our office to help you so that your insurance carrier will make proper reimbursement for services performed at this office. However, please remember that your insurance contract is made between you and your insurance carrier and not with our office. Your insurance rules and benefits are specified in your contract. You are responsible for knowing your benefits and following the rules of your plan. Verification of your insurance or the receipt of a prior authorization does not guarantee payment by your plan. The ultimate obligation for payment of services rests with you. Please contact your insurance company regarding co-pays or deductible requirements.

I, (the patient) also understand and acknowledge that I am personally responsible to pay Advanced Gastroenterology, P.C. a division of Arizona Gastrointestinal Associates, in full for services that my health insurer will not cover due to nonpayment of my health insurance premiums.

Participating Provider Plans: If we are contracted with or are participating providers with your insurance plan, we will submit your claim to your insurance company. If your insurance company has not paid your account in full within 45 days, we may request your assistance in collecting from your carrier.

If you insurance company requires a referral, you are responsible for obtaining that referral prior to the services being rendered. This needs to be done for each visit to our office, if necessary.

Private insurance: As a courtesy, we will submit a claim to your private insurance. If your insurance does not respond to our claim within 30 days, you will be responsible for the entire balance of your account. Additionally, once your insurance sends us payment for your services, any balance not paid in full by them will be your responsibility.

Medical Records Fees: There will be a fee of seventeen cents (.17) per page to copy records. We will provide records to your physician, with a signed consent, at no charge.

Missed Appointments: Unless cancelled at least **24 hours in advance**, our policy is to charge for the missed appointment at the rate of a new or follow up office visit, this included **scheduled procedures**. We will keep your credit card on file and will bill the charge to that credit card account.

Interest: We reserve the right to charge interest in the amount of 10% as provided by state law. If a payment is not kept current and we are forced to send your account to collections, we will add the 33 1/3% collection fee to your total balance.

Financial Policy Acceptance:

I certify that I have read and fully understand the financial policies of ADVANCED GASTROENTEROLOGY, P.C.

Patient signature: _____ Date: _____

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To our patient:

If the doctor/provided has ordered any test: blood tests or x-rays, it is possible these tests will not be covered by your insurance company. We make every effort to confirm coverage for services the doctor may request, but it is also the responsibility of the patient to ask when services are rendered. You may also call your insurance company prior to the testing to verify coverage. If you have any questions regarding this, please ask. We appreciate the opportunity to help provide your health care.

Thank you.

_____ _____

Patient Signature Date

_____ _____

Printed Name Date of Birth

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Dear Patient,

Please schedule your follow up visit to review any results. We will no longer be able to give those results over the telephone. This includes any labs, ultrasound, CT scans, Procedures or Biopsies.

It is your responsibility to make sure that you have a follow up appointment.

Thank you for allowing us to participate in your health care needs.

Thank you.

_____ _____

Patient Signature Date

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We are happy to announce our new patient portal. Through the patient portal, you will be able to view your upcoming appointments, diagnostic studies such as labs, ultrasounds, etc.

Please provide the following so that you may receive an invitation to the portal.

Name (please print) _____

Date of birth _____

E-mail address _____

Signature: _____ Date _____

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