Scottsdale Gastroenterology Specialists
3501 N. Scottsdale Rd. Suite 150, Scottsdale, AZ 85251
P: 480.949.1260 F: 480.219.6596

Patient's Name_____ DOB: _____
First Name Middle Last Name □ Male □ Female

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated Occupation: _____

Street Address_____

City/State/Zip Code_____

Primary Phone: (_____) - _____ Alt/Work Phone (_____) -_____

Email: _____ Access to Patient Portal: Y N

Preferred Method of Contact: Primary Phone Alt/Work Phone Email **Please leave message:** YES NO

Race: American Indian or Alaska Native Asian Black/African American Hispanic/Latino
Native Hawaiian or Other Pacific Islander White/Caucasian Other Unknown Patient declines to provide information
Ethnicity: Hispanic or Latino Not Hispanic or Latino Patient declines to provide information

Patient's Employer: _____
Check One: FT PT NOT EMPLOYED DISABLED RETIRED STUDENT

In case of emergency, contact name_____ (contacted for emergency ONLY)
Phone: _____ Relationship to Patient_____

Referring Physician's Name: _____ Phone_____
Primary Care Physician Name: _____ Same Phone: _____

Primary Insurance Name: _____
Subscriber's Name: _____ OR _____ Self Employer: _____
Date of Birth: _____
Relationship: _____Policy # _____Group #_____

Secondary Insurance Name: _____
Subscriber's Name: _____ OR _____Self Employer: _____
Date of Birth: _____
Relationship: _____ Policy #_____ Group #: _____

Pharmacy: _____ **Address/Cross St.** _____
Phone: _____

I assign all medical/surgical benefits to Arizona Gastrointestinal Associates, PLC and understand that I am financially responsible for all charges regardless of payment or non-payment from my insurance company. I authorize payment be made to the provider. In the event that the payment is made to the policyholder or patient, I agree to submit payment in full, to the provider's office upon receipt of such payment.

I hereby authorize the provider to release or procure all information necessary to secure the payments of benefits, for treatment purposes and any other 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 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 in the office at my request.

_____ _____ _____
Patient/Guardian Signature **Guardian's Name** **Date**

Scottsdale Gastroenterology Specialists
S. Jaffrey Kazi, M.D.
John P. Dorsey, PA-C
Deidra Wood, R.D.N.
3501 N. Scottsdale Rd. Suite 150
Scottsdale, AZ 85251
P: 480.949.1260 F: 480.219.6596

Financial Policy

Thank you for choosing Scottsdale Gastroenterology Specialists as your healthcare provider. The following is an explanation of our financial policy which we require you to read and sign prior to receiving services. Due to Scottsdale Gastroenterology Specialists office policies, refusal to sign the Financial Policy will result in a cancelled appointment.

- If you have provided us with insurance information, we will submit claims to your insurance plan(s) and will assist you in any way we reasonably can to facilitate getting your claims paid. However, your insurance plan(s) may need you to supply certain information directly and it is your responsibility to comply with this request.
- Once your insurance claims have been processed by your insurance plan(s), a statement will be sent to you for any deductible, co-insurance, co-payment or other remaining balance not paid by your insurance plan(s).
- Verification of Eligibility and benefit information obtained from your insurance company is not a guarantee of payment. Should any portion of our claim be denied by your insurance carrier, you are responsible for all unpaid and/or non-covered charges.
- If your insurance policy requires a referral for your office visit, procedure, anesthesia or for the facility where services are rendered, you are responsible for verifying that a valid referral is on file at our office for the service(s) prior to the date of service.
- Your medical records can be copied upon your written authorization. Please allow up to 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. SGS may charge $0.50 (fifty cents) per page. If charged, this fee is due upon patient authorization prior to the release of the records. Postage may also be incurred in addition to the copying fee. To avoid postage fees, the patient or guardian may pick up records in the office of choice. There will be no charge for records sent to another physician's office involved with your continuity of care.

Payment: Patient copays are collected at check-in on the day of your appointment.

Payment in full is due upon receipt of your first statement. We accept payment by cash, credit card (Visa, MasterCard, Discover and American Express), personal check or money order. If you wish to make a payment online, please visit, azgastrohealth.com and complete the required fields. There will be a service charge of $35.00 added to a return check from your financial institution for any reason.

(SGS Financial Policy Continued)

If you are unable to pay your balance in full, it is your responsibility to contact our Billing Office to establish a mutually agreeable, interest-free payment plan as soon as possible and to discuss other financial resources which may be available.

Cancelled Appointments: We understand that life happens and things come up beyond your control. So we ask that you please give us proper notice if you are unable to keep your appointment so that another patient can be seen. **Cancellations of less than 24 hours-notice may be charged a $50.00 fee.**

No Show Appointments: If you are unable to keep your scheduled appointment, we request that you call our office to notify us. Leaving a message on our main voice mail box or with our answering service after hours would be appreciated.
No show patient office visit appointments will be charged a $50.00 fee.
No show or procedure appointments cancelled less than 48 hours of the procedure date, will be charged a $200.00 fee.

I, _____, (**print** patient/responsible party name) agree that I have read and fully understand the financial policies of Scottsdale Gastroenterology Specialists, a division of, Arizona Gastrointestinal Associates. I also acknowledge that all questions I may have regarding these policies were answered adequately by SGS staff and I am satisfied with the explanation provided.

_____ _____

Patient / Responsible Party Signature Date

Scottsdale Gastroenterology Specialists

HIPAA PRIVACY ACKNOWLEDGEMENT

_____ I have received or read the HIPAA Privacy Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

_____ I hereby authorize Scottsdale Gastroenterology Specialists to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved in my care.

_____ I also authorize the release of information that may be necessary in the processing of any insurance claims.

_____ I also authorize the release of any medical records including pharmacy records to Scottsdale Gastroenterology Specialists upon request.

PERSONAL REPRESENTATIVES

(Family members, attorneys, etc.): I hereby authorize Scottsdale Gastroenterology Specialists, and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

_____ **Decline** (I do not authorize permission to discuss, send and/or receive medical information to/with others.)

FAXES When expedient, I authorize the transmittal of my records by FAX. I understand that transmission by FAX, but its very nature, is not confidential.

MESSAGES

It is OK to leave a message on my home phone voice mail #: Yes No

It is OK to leave a message on my cell phone voice mail #: Yes No

It is OK to leave a message on my work phone voice mail #: Yes No

Patient Name (Please **Print**): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF PRETECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

PLEASE **OBTAIN** INFORMATION FROM:

_____
Name of Provider/ Clinic/ Organization

_____
Street Address

_____
City, State, Zip Code

PLEASE **SEND** INFORMATION TO:

_____
Name of Provider/ Clinic/ Organization

_____
Street Address

_____
City, State, Zip Code

I **AUTHORIZE** the following information to be disclosed: (Please check mark all that apply)

_____ Entire GASTROENTEROLOGY Record
_____ Immunization Record
_____ Lab Tests
_____ TB Test
_____ Billing Records
_____ HIV Record
_____ STD Record
_____ Psychiatric/ Mental Health
_____ Alcohol/ Substance Abuse
_____ Other: _____

REASON for disclosure of health information: (Please initial only ONE option)

_____ At my request
_____ Continuing Care
_____ Insurance
_____ Other: (please specify) _____

I authorize the use and disclose of the medical records indicated above in the possession of Arizona Gastrointestinal Associates, P.L.C. Any further disclosure of medical record information by the receptionist(s) is not authorizes 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. This authorization may be revoked in writing by the undersigned at any time prior to the release of the information from the disclosing part. 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 three (3) months from the date of signature. A copy of this signed authorization is valid as an original.

_____
Patient Signature

_____
Date

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Colonoscopy Notification Statement

Types of Colonoscopy:

Diagnostic/therapeutic colonoscopy:
Patient has past and/or present gastrointestinal symptoms. Polyps, or gastrointestinal disease.

Surveillance/ High Risk Colonoscopy:
Patient has no gastrointestinal symptoms (either past or present), BUT has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).

Preventative Screening Colonoscopy:
Patient has no gastrointestinal symptoms (either past or present), is over the age of 50, AND has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

- ***Who will bill me?*** You may receive bills from separate entities associated with your procedure, such as
  1. **Physician (AGA)**
  2. **Facility (Arizona Digestive Center or Hospital)**
  3. **Anesthesia (Scottsdale Anesthesia Group or hospital associated Anesthesia group)**
  4. **Pathologist (Miraca or hospital pathologists)**
  5. **Laboratory if blood work is required**
- ***How will I know what I will owe?*** Call your insurance carrier and verify the benefits and coverage by asking the following questions. Possible codes for your procedure are listed above. (You will need to give the insurance representative your preoperative CPT and reason for procedure.)
  1. **Is the procedure and diagnosis covered under my policy?**
  2. **Will the diagnosis code be processed as preventative, surveillance, or diagnostic and what are my benefits for that service? (Benefits vary based on how the insurance company recognizes the diagnosis).**
  3. **Will I owe any coinsurance and/or deductible amounts?**
  4. **Is the facility in network?**
  5. **Are there age and/or frequency limits or my colonoscopy? (e.g. one every ten years over the age of 50, one every two years for a personal history of polyps beginning at age 45, etc.)**
  6. **If the physician removes a polyp, will this change your out of pocket responsibility? (A biopsy or pocket expenses. (Insurance Carriers vary on this policy.)**
     - **Representative's Name: _____ Call Reference #: _____ Date: _____**

Can the physician change, add, or delete my diagnosis so that it can be considered a preventative screening colonoscopy? NO! The patient encounter is documented as a medical record from information you have provided as well as an evaluation and assessment from the physician. It is a binding legal document that cannot be changed to facilitate better insurance coverage.
If your insurance plan has a high deductible, you may be asked to make a deposit prior to your procedure.

_____ _____
Patient Signature **Date**

_____
Patient Printed Name

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Arizona Digestive Center

Scottsdale Anesthesia Group

Patient Name: _____

Account #: _____

Financial Policy for Out-of-Network Insurance

Please be advised that our anesthesia services for sedation may possibly be out of network with your insurance company. We will gladly check your out of network benefits and our insurance benefits specialist will go over them with you if you have any questions. You are also more than welcome to contact your insurance company to verify, if you are in network or out of network by utilizing our Tax ID # 32-0229237. We still bill all of your services to your insurance company. It is, however, our expectation that you (the member) will receive all payments and correspondence directly from your insurance company.

Please understand that one you receive payment for the anesthesia service from your insurance company you should endorse and mail check with copy of explanation of benefits to our office address Dept. 993, PO BOX 29901 Phoenix, AZ 85038-0901, otherwise you will be liable for the full fee for anesthesia.

If your insurance is your secondary insurance, we will bill them for you after the primary insurance payment it received. At that time, we will send you a bill for the secondary balance and ask that you pay us that amount. Your insurance company should reimburse you directly.

Our goal is to make this billing process as efficient and convenient for all parties involved. If you have any questions at any time regarding this process, please contact Maria our benefits specialist at (480)219-6662 x 216. We will always be here to help make sure that you do get your appropriate reimbursement.

By signing below, I acknowledge that I agree to the terms above and I am accepting treatment by a provider who has informed me that they are out of network with my insurance.

_____ _____

Signature of Patient/ Guarantor Date

Scottsdale Gastroenterology Specialists
a subdivision of
arizona gastrointestinal associates

Jaffrey Kazi M.D. , Robert G. Leon. M.D., Ichha Sethi P.A-C
3501 N Scottsdale Rd, Suite 150 Scottsdale. Arizona 85251
(P) 480.949.1260 (F) 480.947.4702

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____
MRN:_____ Date Of Birth:_____
Age:_____ Notes:_____

Email
Please check one as your preferred email for communications
☐ Personal:_____ ☐ Work:_____

Race
Select one or more
☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law

Sex
☐ Male ☐ Female ☐ Other

Preferred Language
☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Pharmacy

Name Address Phone

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies
☐ Penicillins ☐ Sulfa (Sulfonamide Antibiotics) ☐ Iodine ☐ Latex Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Flu vaccine When:_____

☐ Hepatitis A When:_____

☐ Hepatitis B When:_____

☐ TB skin Test When:_____

☐ pneumovax When:_____

Past or Present Medical Conditions

☐ None

☐ Colon polyps When:_____

☐ Colon cancer When:_____

☐ Dysphagia (problems swallowing) When:_____

☐ GERD When:_____

☐ IBS When:_____

☐ Hemorrhoids When:_____

☐ Diverticulosis When:_____

☐ Crohn's Disease When:_____

☐ Barrett's Esophagus When:_____

☐ Bowel Obstruction When:_____

☐ Celiac Disease When:_____

☐ Ulcerative Colitis When:_____

☐ Gallstones When:_____

☐ Fatty Liver When:_____

☐ Gastric Cancer When:_____

☐ Pancreatitis When:_____

☐ Peptic ulcer disease When:_____

☐ Kidney Disease When:_____

☐ Cirrhosis When:_____

☐ Hepatitis C When:_____

☐ Hepatitis B When:_____

☐ High blood pressure When:_____

☐ TIA When:_____

☐ CVA When:_____

☐ Diabetes Mellitus When:_____

☐ Depression When:_____

☐ Anxiety disorder When:_____

☐ Seizures When:_____

☐ Sleep apnea When:_____

☐ Pacemaker When:_____

☐ Coronary Artery Disease (CAD) When:_____

☐ Congestive Heart Failure When:_____

☐ History of blood clots When:_____

☐ Asthma When:_____

☐ C.O.P.D. When:_____

☐ Oxygen Use When:_____

Other:_____

Other:_____

Other:_____

Previous Procedures

☐ None

☐ Colonoscopy When:_____

☐ EGD When:_____

☐ Colon Resection When:_____

☐ Small bowel surgery When:_____

☐ Gastric By-Pass When:_____

☐ Hemorrhoidectomy When:_____

☐ Gallbladder removed When:_____

☐ Gastric Band When:_____

☐ Hiatal hernia surgery When:_____

☐ Aortic Valve Replacement When:_____

☐ Carotid Stent Left When:_____

☐ Appendectomy When:_____

☐ Splenectomy When:_____

☐ Hysterectomy When:_____

Other:_____

Other:_____

Social History

Occupation:_____ Number of Children:_____

Alcohol

○ None

Type	Quantity	Number	Frequency

Tobacco

Smoking Status

○ Current every day smoker ○ Current some day smoker ○ Former smoker ○ Never smoker

○ Smoker, current status unknown ○ Light tobacco smoker ○ Heavy tobacco smoker ○ Unknown if ever smoked

Drug Use

○ None

Type	Quantity	Number	Frequency

Family Medical History

○ No knowledge of family history

No family history of

○ Celiac Disease
○ Crohn's disease
○ Liver Disease
○ Polyp of colon
○ Colon Cancer
○ IBD, Indeterminate
○ Pancreatic cancer
○ Ulcerative Colitis

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son
Stomach Cancer	○	○	○	○	○	○
Celiac disease	○	○	○	○	○	○
Liver Cancer	○	○	○	○	○	○
Pancreatitis	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Uterine Cancer	○	○	○	○	○	○
Carcinoma, ovarian	○	○	○	○	○	○
Brain Cancer	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○
Other Cancer: _____	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic
○ None

	Y	N
strong allergic reactions or urticaria	○	○

Constitutional
○ None

	Y	N
fatigue	○	○
fever	○	○
chills	○	○
weight gain	○	○
weight loss	○	○

ENMT
○ None

	Y	N
dizziness	○	○

Cardiovascular
○ None

	Y	N
chest pain	○	○
shortness of breath with exercise	○	○
irregular heart beat	○	○
palpitations	○	○
fainting	○	○

Respiratory
○ None

	Y	N
cough	○	○
shortness of breath with exercise	○	○
wheezing	○	○
Oxygen dependence	○	○

Gastrointestinal
○ None

	Y	N
abdominal pain	○	○
Abdominal distention/bloating	○	○
stomach cramps	○	○
heartburn	○	○
gas	○	○
nausea	○	○
vomiting	○	○
change in bowel habits	○	○
diarrhea	○	○
constipation	○	○
rectal bleeding	○	○
Ascites	○	○
jaundice	○	○

Hematologic/Lymphatic
○ None

	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○

Integumentary
○ None

	Y	N
hives	○	○
itching	○	○
rashes	○	○

Musculoskeletal
○ None

	Y	N
arthritis	○	○
joint pain	○	○
back pain	○	○
muscle weakness	○	○

Neurological
○ None

	Y	N
dizziness	○	○
fainting	○	○
migraine	○	○
headaches	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○

Psychiatric
○ None

	Y	N
anxiety	○	○
panic attacks	○	○
depression	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

○ Yes ○ No