Patient Registration Form

Patient Information

Name (First / Middle Initial / Last): _____ Title: _____ Date of Birth: _____

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 ☐ Text ☐ Email

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Gender: _____ Social Security #: _____

Referring Physician: _____ Primary Care Physician: _____

Preferred Language: _____ **Race:** ☐ White ☐ Black or African American ☐ Asian

☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ 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: _____ Phone: _____

Emergency Contact (This person will be contacted in the case of an emergency ONLY)

Name: _____ Relationship: _____ Phone: _____

Additional Information

Occupation: _____ Employer: _____

Insurance Information

Primary Insurance Company: _____ Relationship to Subscriber: _____ ID #: _____

Group #: _____ Network: _____ Claims Address: _____

Subscriber Name: _____ Birth Date: _____ Subscriber Social Security #: _____

Secondary Insurance Company: _____ Relationship to Subscriber: _____ ID #: _____

Group #: _____ Network: _____ Claims Address: _____

Subscriber Name: _____ Birth Date: _____ Subscriber Social Security #: _____

Pharmacy Information

Name: _____ Phone: _____

Cross Streets: _____ Address: _____

☐ 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 in 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: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ Phone _____

PLEASE **OBTAIN** INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone: _____ Fax: _____

PLEASE **SEND** INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone: _____ Fax: _____

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 disclosure of the medical records indicated above in the possession of Arizona Gastrointestinal Associated, PLC. Any further disclosure of medical record information by the receptionist(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. 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 three (3) months from the date of signature. A copy of this signed authorization is valid as an original.

_____ _____
Patient Signature Date

arizona
gastrointestinal
associates

8761 E. Bell Rd Suite 105 Scottsdale, AZ 85260
Ofc : 480.322.6222 Fax: 480.219.6596

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 services:

- Full payment of copays and deductibles are due at the time of service. We accept cash, checks and credit cards. There will be a $35.00 service fee charge on returned checks.
- Missed appointments without adequate notice will be charged a $50.00 fee for office visits (24hr notice) and $150.00 for procedures (48hr 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 for verifying a referral is on file for your 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're 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: _____

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 you're 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 will still bill all 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 once 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 is 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

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Account #:

NOTICE TO PATIENTS

State law requires a physician to notify a patient that the physicians has a financial interest in a separate diagnostic facility to which the physician is referring the patient for non-routine services prescribed by the physicians, and whether these services are available elsewhere on a competitive basis.

We support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, this form advises you that our Medical Providers have a financial interest in Arizona Digestive Center, the licensed ambulatory surgery center where we have recommended you have the endoscopic procedure we have prescribed for you. Further, the endoscopic procedure that we have prescribed for you is available elsewhere on a competitive basis.

The law requires us to obtain your written acknowledgement that you have read and understand the disclosures made in this form. Accordingly, please sign and date this form in the space provided below. Your executed form will be kept in your patient file.

ACKNOWLEDGEMENT

I have read this Notice to Patients, and I understand the disclosures that it contains.

_____ _____ _____

Signature of Patient or Guardian | Date of Birth | Today's Date

Nizar Ramzan MD NPI 1992733992
S. Jaffrey Kazi MD NPI 1164440293

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).

Preventive 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 the
  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. 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 for 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 polyp removal may change a screening benefit to a medical necessity benefit which = more out of 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

Colon & Digestive Health Specialists

S. Jaffrey Kazi, MD • Nizar Ramzan, MD, AGAF • Kelly Kollman, PA-C

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

	Y	N
◯ None		
strong allergic reactions or urticaria	◯	◯

Constitutional

	Y	N
◯ None		
fatigue	◯	◯
fever	◯	◯
chills	◯	◯
weight gain	◯	◯
weight loss	◯	◯

ENMT

	Y	N
◯ None		
dizziness	◯	◯

Cardiovascular

	Y	N
◯ None		
chest pain	◯	◯
shortness of breath with exercise	◯	◯
irregular heart beat	◯	◯
palpitations	◯	◯
fainting	◯	◯

Respiratory

	Y	N
◯ None		
cough	◯	◯
shortness of breath with exercise	◯	◯
wheezing	◯	◯
Oxygen dependence	◯	◯

Gastrointestinal

	Y	N
◯ None		
abdominal pain	◯	◯
Abdominal distention/bloating	◯	◯
stomach cramps	◯	◯
heartburn	◯	◯
gas	◯	◯
nausea	◯	◯
vomiting	◯	◯
change in bowel habits	◯	◯
diarrhea	◯	◯
constipation	◯	◯
rectal bleeding	◯	◯
Ascites	◯	◯
jaundice	◯	◯

Hematologic/Lymphatic

	Y	N
◯ None		
bleeding gums or palpable lymph nodes	◯	◯
easy bruising	◯	◯

Integumentary

	Y	N
◯ None		
hives	◯	◯
itching	◯	◯
rashes	◯	◯

Musculoskeletal

	Y	N
◯ None		
arthritis	◯	◯
joint pain	◯	◯
back pain	◯	◯
muscle weakness	◯	◯

Neurological

	Y	N
◯ None		
dizziness	◯	◯
fainting	◯	◯
migraine	◯	◯
headaches	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯
tremors	◯	◯

Psychiatric

	Y	N
◯ None		
anxiety	◯	◯
panic attacks	◯	◯
depression	◯	◯

Consent to Import Medication History

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

◯ Yes ◯ No

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: