Island View Gastroenterology Associates
168 N Brent St #404
Ventura, CA 93003
805-641-6525

DATE:_____

PATIENT NAME:_____ PREFER TO BE CALLED:_____

DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY #:_____

GENDER: MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED WIDOW DIVORCED SEPARATED

PREFERRED PHONE #: HOME MOBILE WORK :_____ **ALTERNATE PHONE #**: HOME MOBILE WORK_____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

E-MAIL:_____ OCCUPATION:_____

EMPLOYER:_____ EMPLOYER PHONE:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

EMERGENCY CONTACT NUMBER:_____

REFERRING PROVIDER?:_____ PRIMARY CARE PROVIDER?:_____

PRIMARY INSURANCE COMPANY:_____

SUBSCRIBER ID:_____ GROUP:_____

SECONDARY INSURANCE COMPANY:_____

SUBSCRIBER ID:_____ GROUP:_____

IF OTHER THAN THE PATIENT, PLEASE TELL US ABOUT THE POLICY HOLDER

POLICY HOLDER'S NAME:_____ POLICY HOLDER'S DATE OF BIRTH:_____

POLICY HOLDER'S PHONE #:_____ RELATIONSHIP TO PATIENT:_____

POLICY HOLDER'S EMPLOYER:_____ EMPLOYER PHONE #:_____

STREET ADDRESS OF POLICY HOLDER:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PLEASE SIGN THE FOLLOWING:

I assign to this provider all benefits to which I am entitled for medical expenses related to service. I understand that I am financially responsible to this provider for charges not covered by this assignment. I **UNDERSTAND IF MY INSURANCE IS NO LONGER IN EFFECT THE BALANCE IS MY RESPONSIBILITY. I WILL ALSO NOTIFY YOU OF ANY CHANGES IN MY INSURANCE PRIOR TO ANY PROCEDURES OR VISIT WITH YOU AS I UNDERSTAND MY NEW INSURANCE MAY NOT COVER THESE CHARGES UNTIL YOU VERIFY MY BENEFITS.**

X_____

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PREPARATION OF INSURANCE CLAIMS ON MYSELF, AND AUTHORIZE THE INSURANCE TO MAKE PAYMENT DIRECT TO THE PHYSICIAN ON ANY UNPAID CLAIM. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE CLAIMS, INCLUDING ELECTRONIC SUBMISSIONS.

X_____

ISLAND VIEW GASTROENTEROLOGY ASSOCIATES (IVGA)
Charles L. Menz, M.D., Inc. * Kip D. Lyche, M.D., Inc. * Benito A. Pedraza, M.D., Inc. * Chetan V. Gondha, M.D., Inc. Joel A. Alpern, M.D., Inc. * Laya Nasrollah, M.D., Inc. * Adnan Ameer, M.D. Inc. *
Tatyana Mitina, PA- C *Krista Blaustien, PA-C * Phil Mckay, PA-C
168 N Brent Street, Suite 404, Ventura, CA 93003
Telephone: (805)641-6525 Fax (805) 641-6530

We face unprecedented disruption in routine operations of our clinic due to the COVID 19 pandemic. We have adopted a telemedicine platform to continue to provide patient services when there are limitations on physical interaction. Telemedicine is the delivery of health care services and clinical information to patients and providers in remote areas using audio-video conferencing technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone.

Informed Consent for Telemedicine Services

- I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- I understand that the telemedicine visit will be done through a two-way video link-up or audio only telephone services. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.
- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telemedicine.
- I understand that I will be responsible for any copayments or coinsurance that apply to my telemedicine visit.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Preferred telehealth phone number: _____

Client Signature:

_____

Printed Name:

_____

Island View Gastroenterology Associates

Gastroenterology • Hepatology • Endoscopy
168 North Brent Street, Suite 404 • Ventura, CA 93003
Telephone: (805) 641-6525 • FAX: (805) 641-6530

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

If applicable, may we text you? ☐ **YES** ☐ **NO**

If applicable, may we email you? ☐ **YES** ☐ **NO**

If YES, we may use email or text messages to communicate with you:

- IVGA may use text messages or email to remind you of appointments.
- IVGA may use text message or email to remind you of when visits or procedures are due.
- IVGA may use text messages or email to promote patient healthcare education.
- IVGA text messages are two way. Texts are not monitored 24/7. Text messages initiated by you may not be HIPAA compliant, through its continued use, you acknowledge and consent to the exchange of information.

☐ Acknowledged

May we leave a message on your answering machine at home? ☐ **YES** ☐ **NO**

- Leave a message with a call back number only. Check here: ☐ YES

May we leave a message on your cell phone? ☐ **YES** ☐ **NO**

- Leave a message with a call back number only. Check here: ☐ YES

Do you have a preferred method of communication not listed above, if YES please list below:

_____

_____

May we discuss your medical condition with any member of your family? ☐ **YES** ☐ **NO**

If YES, please name the members allowed:

_____

_____

Signature:_____

This consent was signed by: _____DOB: _____

Island View Gastroenterology Associates

168 N. Brent Street Suite 404
Ventura, CA 93003
Phone: (805) 641-6525 Fax: (805) 641-6530

1901 Solar Drive Suite 205
Oxnard, CA 93036
(805) 973-1227

Follow My Health is our new and innovative secure patient portal that is designed to improve the exceptional care you recieve. Access to this patient portal provides complete electronic documentation of the care you receive with physicians who participate.

Features

- ✓ **Ability to request medication refills from your health care provider.**
- ✓ **You can ask your provider questions about your health.**
- ✓ **You can ask your provider's staff questions about your bill.**
- ✓ **You can ask your provider's staff questions about your appointment.**
- ✓ **Access your records anytime from any device that has internet access.**

Your Follow My Health health record will include:

- ✓ **Continuously updated electronic records from your healthcare providers**
- ✓ **Medication List**
- ✓ **Laboratory and other test results**
- ✓ **Personalized educational resources**
- ✓ **Immunization records**
- ✓ **Your medical history and detailed information about your visits**
- ✓ **Allergies**

- o We will email you an invitation to enroll in Follow My Health.

- o **Email Address:**_____

ISLAND VIEW GASTROENTEROLOGY ASSOCIATES

168 N. Brent Street, Suite 404, Ventura CA 93003
Phone: **805.641.6525 Fax**: 805.641.6530

NOTICE OF PRIVACY PRACTICES

This Notice is effective March 26, 2013

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

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for *all* medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request. Please contact Island View Gastroenterology Associates at 805.641.6525

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you.
- Explain your rights with respect to medical information about you.
- Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Privacy Officer at **805.641.6525**

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer at **805.641.6525**.

1. Treatment

We may use and disclose medical information about you to provide healthcare treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

2. Payment
We may use and disclose medical information about you to obtain payment for healthcare services that you received. This means that, within the health department, we may *use* medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may *disclose* medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan *before* you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service.

3. Healthcare Operations
We may use and disclose medical information about you in performing a variety of business activities that we call "healthcare operations." These "healthcare operations" activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
- Providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving healthcare and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

4. Telephone Communications
We may use and disclose medical information to contact and remind you about appointments, insurance items, or information about alternative treatment options. The following appointment reminders are used by the Practice: a) text message; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

5. Sign-in sheet
We may use and disclose medical information about you by having you sign in when you arrive at our center. We may also call out your name when we are ready to see you.

6. Persons Involved in Your Care
We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors' information, contact our Privacy Officer at **805.641.6525**.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

7. Required by Law
We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

8. National Priority Uses and Disclosures
When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer at **805.641.6525.**

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.
- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the healthcare system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.
- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Workers' compensation:** We may disclose medical information about you in order to comply with workers' compensation laws.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities and

national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

9. Authorizations
Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission):

- ❑ Uses and disclosures for marketing purposes.
- ❑ Uses and disclosures that constitute the sale of medical information about you. (We are prohibited from selling your PHI without your express written authorization/)
- ❑ Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- ❑ Any other uses and disclosures not described in this Notice.

10. Change of Ownership
In the event that this physician practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or facility.

YOUR RIGHTS: You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights

1. Right to a Copy of This Notice
You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be in our waiting area. If you would like to have a copy of our Notice, please ask the receptionist for a copy.

2. Right of Access to Inspect and Copy
You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. You may write us a letter requesting access or fill out a **Patient Authorization for Use or Disclosure of Protected Health Information**. Such Forms are available from our receptionist.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies, to the extent we have electronic records, of your medical records will be limited to the direct labor costs associated with fulfilling your request.

We may be able to provide you with a summary or explanation of the information. Contact our Privacy Officer for more information on these services and any possible additional fees.

3. Right to Have Medical Information Amended
You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information. You may either write us a letter requesting an amendment or fill out an **Amendment Request Form**. Amendment Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made
You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an **Accounting Request Form**, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

5. Right to Request Restrictions on Uses and Disclosures
You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

6. Right to Request an Alternative Method of Contact
You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter

or fill out an **Alternative Contact Request Form**. Alternative Contact Request Forms are available from our Privacy Officer.

7. Right to Notification if a Breach of Your Medical Information Occurs
You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- ❑ A brief description of what happened;
- ❑ A description of the health information that was involved;
- ❑ Recommended steps you can take to protect yourself from harm;
- ❑ What steps we are taking in response to the breach; and,
- ❑ Contact procedures so you can obtain further information.

8. Right to Opt-Out of Fundraising Communications
Island View Gastroenterology Associates does not conduct fundraising or use communications like the U.S. Postal Service or electronic email for fundraising.

Complaints
If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will <u>not</u> take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

Nicole Cook
168 North Brent Street, Suite 404
Ventura, CA 93003
805.641.6525

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

<u>Toll-Free Phone</u>: 1-(877) 696-6775

<u>Website</u>: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

<u>Email</u>: OCRComplaint@hhs.gov

ISLAND VIEW GASTROENTEROLOGY ASSOCIATES

168 N. Brent Street, Suite 404, Ventura CA 93003
Phone: **805.641.6525** Fax: 805.641.6530

Patient Acknowledgement
Receipt of Privacy Notice

I, _____[Patient Name]_____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Island View Gastroenterology Associates. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Personal Representative (if applicable)

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Patient offered Notice of Privacy Practices but refused to sign acknowledgement □

Staff Signature:

Date:

Revised September 2013

ISLAND VIEW GASTROENTEROLOGY ASSOCIATES (IVGA)

168 N Brent Street, Suite 404, Ventura, CA 93003
Telephone: (805)641-6525 Fax (805) 641-6530

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. Island View Gastroenterology Associates has provided well over 30 years of service to Ventura and the surrounding communities. The physicians at Island View Gastroenterology Associates represent some of the finest in California and it is our goal to provide our patients with the highest level of medical and surgical treatment in an environment that fosters a close patient-physician relationship.

We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurse practitioners, medical assistants, and office staff work closely to support your patient care.

Our office is open Monday through Friday from 8:00am-5:00pm. Please note that our schedulers are available every day and will do their best to accommodate you. Should you ever need urgent after hours care you can reach the on-call physician by calling our office directly.

We request that you have a copy of your medical record be sent to us; this includes labs, scans, and office notes. If your former providers are affiliated with the CMH network this should not be necessary. If you do not have access to your medical records please let our staff know where you have had previous lab work or scans done and they will be happy to gather these for you.

To better our patient experience you will now have the ability to complete all forms online at your convenience prior to your appointment. You will receive an email 5 days prior to your visit. Click on the link provided in the email to begin. Verify your information. Complete your necessary intake forms. Once completed you'll be all checked in and ready for your appointment with IVGA! If you are unsure if we have your email please call or text us so we can update your information. If you do not want to complete your forms through the Patientlink secure portal you can also download them from our website www.IslandViewGastro.com or request paper forms be mailed to you or given to you at the time of your appointment. We will need copies of your health insurance identification card as well as a photo I.D and a complete list of all of your medications. Should you have any trouble please make sure to bring these to your appointment.

Your copay will be due at the time of service. IVGA's billing department will happily submit a claim insurance for your reimbursement as long as you are free to choose your own gastroenterologist. Before you visit, we always suggest you contact your health insurance company to be sure we are in-network. If your insurance requires authorization we ask you to verify with our office that we have a copy of the authorization and the date of service falls within the authorized dates.

Once again, we would like to thank you for choosing us as your healthcare provider. We look forward to working with you.

Sincerely,

The Providers and Staff of Island View Gastroenterology Associates