Patient Demographic Form

Legal Last Name	Legal First Name	Middle Name
Social Security Number (VA and Tri-Care Patients Only)	Date of Birth	Gender: Male Female Another Gender
Address		
City	State	Zip

What is Your Race? (Check one or more)

☐ Alaskan Native ☐ Asian ☐Black/African American ☐ Multi-Racial

☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ____________________

Primary Language	Hispanic Origin? Yes No	Marital Status:	Medical Providers involved in my care:

Home Phone # May Leave a Message ☐ Yes No	Preferred Pharmacy and Location:
Cell Phone # May Leave a Message ☐ Yes No	Employer / Employer Phone / May Leave a Message Yes No
Would you like to receive automated appointment reminders? Yes No	Preferred appointment reminders? Voice Message Text
Spouse Name / Spouse DOB	Emergency Contact Name / Relationship / Phone #

POWER OF ATTORNEY

Definition: A legal Document giving a person the power to make decisions for another person (e.g. current medical decisions, financial decisions)

Do you have a power of attorney on file? Yes No

Name of Person who holds the Power of Attorney: ______________________________ Phone:___________________________

PATIENT PORTAL

Alaska Digestive and Liver Disease has a secure and confidential Internet-based portal to enhance communication with our clients. You can use the portal to review your medication, check your latest test results, request prescription refills, and more – 24 hours a day. By providing your email, you are consenting to receive email communications from Alaska Digestive and Liver Disease.

Email Address____@__________

PRIMARY INSURANCE

Primary Insurance Name	ID Number	Group Number
Policy Holder's Name		Relationship of Policy Holder to you:
Medical Claims Submission Address		Policy Holder's Date of Birth

SECONDARY INSURANCE

Secondary Insurance Name	ID Number	Group Number
Policy Holder's Name		Relationship of Policy Holder to you:
Medical Claims Submission Address		Policy Holder's Date of Birth

☐ I authorize Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP to administer medical treatment and access my electronic prescription records for continued care and further treatment

☐ The following facilities (Providence Medical Center, Alaska Regional Hospital, Surgery Center of Wasilla, and/or Alaska Digestive Center) are hereby authorized to review/access my Alaska Digestive & Liver Disease medical record for treatment and diagnostic record for coordination of care.

- **I acknowledge and agree to the terms above:**
- **Patient's Signature:** **Today's Date:**_______________________

Patient Medical History

Name ______________________ **Date of Birth** __________

Reason For Visit ______________________ **Today's Date** __________

MEDICATIONS: Please List the medications you are taking (prescription, over-the-counter, and supplements). Complete each column. Attach additional pages if needed.

Medication Name	Dosage	Frequency			
		1x/day	2x/day	3x/day	as needed
		1x/day	2x/day	3x/day	as needed
		1x/day	2x/day	3x/day	as needed
		1x/day	2x/day	3x/day	as needed
		1x/day	2x/day	3x/day	as needed
		1x/day	2x/day	3x/day	as needed

Are you on any blood thinners (e.g. Coumadin, Plavix, Xarelto, Eliquis, etc.…) YES NO

ALLERGIES

If you have experienced allergies to any of the following, please select the box:

None
X-ray/Radiology Contrast
Other *Please specify:* __________
Latex
Antibiotics *Please specify:* __________

PAST MEDICAL HISTORY

Have you EVER experience any of the following? If the answer is, "Yes," please select the box.

Anemia
Anxiety Disorder
Artificial Joints
Asthma
Acid Reflux
Bleeding Disorder
Blood Clots
Clostridium Difficile
Colon/Rectal Cancer
COPD/Emphysema
On Oxygen
Crohn's Disease
Diabetes

Diverticulosis
Diverticulitis
Heart Attack
Heart Failure
Heart Stents
Heart Valve Replacement
Heart Bypass Surgery
Hepatitis
Hiatal Hernia
High Blood Pressure
High Cholesterol
HIV Infection
Implanted Defibrillator
Irritable Bowel Syndrome

Kidney Disease
Liver Disease
MRSA
Pacemaker
Pancreatitis
Seizure Disorder
Sleep Disorder
Stomach Cancer
Stroke
Thyroid Disorders
Tuberculosis
Ulcerative Colitis
Dementia
Other
Please specify: __________

PAST SURGICAL HISTORY

Have you had any of the following surgeries? If the answer is, "Yes," please select the box.

Appendix Removal
Gallbladder Removal
Weight Loss Surgery

Heart Surgery
Hysterectomy
Other
Please specify: __________

Portion of Bowel Removed
Stomach Surgery

Patient Medical History

Name ______________________ **Date of Birth** ____________

PAST ENDOSCOPIC HISTORY

Type of Endoscopic Procedure	Date	Did they find Polyps?	
		YES	NO
		YES	NO
		YES	NO
		YES	NO

Have you ever had a problem with sedation or anesthesia? YES NO

If yes, please describe: ______________________

SOCIAL HISTORY

Please select all that apply.

Tobacco Use
- Never
- Current Smoker
- Former Smoker
- Chew
- Vape

Alcohol Use YES NO

How many drinks per week ____________

Recreational Drug Use YES NO

Current Use: ____________

Which Form: ____________

FAMILY HISTORY

Have your blood relatives had any of the following? If yes, please select the box for their relationship to you.

Disease	Relationship			
Colon Cancer	Mother	Father	Sibling	Grandparent
Colon Polyps	Mother	Father	Sibling	Grandparent
Esophageal Cancer	Mother	Father	Sibling	Grandparent
Crohn's Disease	Mother	Father	Sibling	Grandparent
Liver Disease	Mother	Father	Sibling	Grandparent
Pancreatic Cancer	Mother	Father	Sibling	Grandparent
Stomach Cancer	Mother	Father	Sibling	Grandparent
Ulcerative Colitis	Mother	Father	Sibling	Grandparent
Gallbladder Problems	Mother	Father	Sibling	Grandparent
Celiac Disease	Mother	Father	Sibling	Grandparent

REVIEW OF SYSTEMS

Do you CURRENTLY have any of the following? If the answer is, "Yes," select the box"

Fatigue	Heartburn	Passing Blood with Stool	Vomiting
Abdominal Pain	Belching	Weight Loss	Nausea
Abdominal Bloating	Regurgitation	Swallowing Difficulty	Chest Pain
Constipation	Diarrhea	Black Tarry Stools	

VACCINATION HISTORY:

Please mark the box if you have that the following vaccinations:

Hepatitis B   Pneumovax   Shingrix   Flu Shot   COVID

______________________   ______________________

Patient Signature

ACKNOWLEDGEMENT & CONSENT

I understand that **Providers: Daryl M. McClendon, MD, Jeffrey W. Molloy, MD, Austin T. Nelson, MD, Martin P. Kaszubowski, MD, and/or Terri L. Tope, ANP** (Referred to below as "The Providers") will use and disclose health information about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information About my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that The Providers' may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various offices, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

We participate with healtheConnect the Alaska health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about healtheConnect medical record sharing policies. You may visit their website at https://healtheconnectak.org/.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of The Providers', and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some and/or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and understand that "The Providers" is not required by law to agree to such requests.

Your Right to Privacy

We understand that you may have concerned relatives and we respect your right to privacy regarding medical information. Please list names of individuals with whom we may share information without additional written consent.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

By signing below, I agree that I have reviewed and understand the above information and that I have received or been offered a copy of the Notice of Privacy Practices.

Patient Signature | Patient Name | Today's Date

FINANCIAL POLICY

Thank you for choosing Alaska Digestive and Liver Disease, LLC for your healthcare needs. We are committed to providing you with the best possible medical care. Prior to your scheduled appointment, please call your insurance company for your benefit coverage. The following information outlines your financial responsibilities related to payment for professional services.

ALL PATIENTS

Patients are responsible for any charges incurred on the account resulting from treatment provided. Any balance due must be paid 30 days from the date of service, unless you have contacted our billing office (907)-569-1333 to make payment arrangements.

Returned Checks – A $35.00 charge will be added to your account for any check returned by your bank for any reason. This will be in addition to charges made by your bank.

No show, Canceled, and Rescheduled services – As a specialty provider our office visits schedule several weeks out, we also perform a large volume of procedures which require considerable time and resources to perform. Please be considerate of your fellow patients and our office staff and allow at least 2 business days' notice for cancellations/rescheduled office visits and 4 business days for procedures. Our office reserves the right to charge patients that do not provide us with the appropriate notification in cancelling/rescheduling the appointment. Our policy is to charge $50.00 for missed office visits and $100 for missed procedures.

Collections – We utilize a collection agency for past due/unpaid accounts over 90 days from the date of service or last payment received. If there are any issues with your account, please contact our office with questions and/or concerns. If there was an insurance issue that was not discussed or resolved prior to your account going to collections, you are responsible for the bill.

INSURED PATIENTS

As a courtesy, our office will bill your primary and secondary insurance for you. We cannot bill your insurance company unless you give us your correct insurance information. Please understand that your medical insurance is a contract between you and your insurance company. We are not party to that contract. Patients are responsible for knowing their coverage limitations and benefits. The billing office cannot guarantee payment for services or quote benefits from your health plan.

• **Referrals and Pre-Authorizations –** Our billing office will attempt to obtain a referral or pre-authorization if your plan requires one. If you choose to be seen prior to receiving the referral or authorization, your insurance may not pay for your appointment.

• **Procedures –** If you receive services at Alaska Digestive Center you will receive a separate bill with a charge for the facility and a separate bill for the physician's time. You may also receive separate bills for anesthesia and any laboratory or pathology services. If your procedure is performed in the hospital you will receive separate bills from the hospital.

• **Helpful Information –** You are responsible for your bill whether your insurance pays or not. To assist you in finding benefit coverage for your plan, call your insurance company with the following information: Provider Name, Provider tax ID if available, and Procedure(s) to be performed.

UNINSURED PATIENTS

Patients without insurance will be required to make a deposit at the time of service. New patients are required to bring $250; established patients $175, and colonoscopy procedures are $1029, and Upper Endoscopy $716. If there is a balance remaining you will receive a statement.

AUTHORIZATION

- I authorize providers Daryl M. McClendon, MD, Jeffrey W. Molloy, MD, Austin T. Nelson, MD, Martin P. Kaszubowski, MD, and/or Terri L. Tope, ANP to submit claims for benefits without obtaining my signature on each and every claim.
- I authorize my insurance(s) benefits to be paid to providers Daryl M. McClendon, MD, Jeffrey W. Molloy, MD, Austin T. Nelson, MD, Martin P. Kaszubowski, MD, and/or Terri L. Tope, ANP. I agree to promptly sign over any checks that I receive within 7 days of receipt. I understand that those charges not covered by my insurance company are my own responsibility, and there is a monthly charge of 1% on the account over 90 days.
- I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

Patient Signature   Patient Name   Today's Date

A. Notifier: Alaska Digestive and Liver Disease
B. Patient Name: **C: Identification Number:**

Advanced 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
	Not indicated for diagnosis and/or treatment in this case	No More than $600

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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMP control number. The valid OMB control number for this information collection is 0938-0566. This time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Daryl M. McClendon, M.D.
Jeffrey W. Molloy, M.D.
Austin T. Nelson, M.D.
Martin P. Kaszubowski, M.D.
Terri L. Tope, ANP

Medicare Long Term Authorization

Name: ____ Medicare #:__________________________

I request that payment of authorized Medicare Benefits be made on my behalf for any service furnished to me by Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP. I authorize any holder of medical or other information about me be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits for related services.

Signature: _______________________________Date:______________________________

(Authorization good for one year from the above date)

Medicare Secondary Payer Questionnaire

1. Are you receiving benefits from any of the following programs?

   Black Lung ___ No ___Yes

   Research Grant ___No ___Yes

   Veterans Affairs ___No ___Yes
   (**If yes to any of the above, STOP** – Medicare is secondary)

2. Was the illness/injury due to a work-related accident/condition?

   ___No _____Yes (**If yes, STOP** – Medicare is secondary)

3. Was illness/injury due to a non-work related accident?

   ____No _____Yes (**If yes, STOP** – Medicare is secondary)

4. Are you entitled to Medicare based on:

   _____Age _____Disability ____ End Stage Renal Disease ____ I am not entitled to Medicare

5. Do you have health insurance sponsored through your own or spouse's employer?

   _____No _____Yes (**If NO** – Proceed to question 7)

6. Does the employer that sponsors your insurance plan employ 100 or more employees?

   _____No _____Yes (**If yes, STOP** – Medicare is secondary)

7. Are you currently a patient in a skilled nursing facility (SNF) such as a nursing home?
   (If yes, we will bill SNF, not Medicare)

   ____ No _____Yes

I confirm that to the best of my knowledge, the above information is accurate.

Please Print Patient Name: ________________________

Patient Signature: _______________________ Date: _____________

_ _ _ _ _ _ — _ _ — _ _ — _ _ — _ _ _ — _ _ — _ _ _ — _ _ _ — _ _ — _ _ — _ _ _ — _ _ — _ _ — _ _ _

My initials below confirm that the above is still accurate as of the date indicated:

___________ ___________ __________ __________ __________ __________

ALASKA DIGESTIVE AND LIVER DISEASE
3851 Piper Street Suite U-466. Anchorage, AK 99508
Phone: 907-569-1333 Fax: 907-569-1433
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT

Name:____**Birth Date:**_____ _____ _____
Other Names Used:____

FROM

☐ **I request patient's information be sent by**:
☐ Dr. Daryl M. McClendon
☐ Dr. Jeffrey W. Molloy
☐ Dr. Austin T. Nelson
☐ Dr. Martin P. Kaszubowski
☐ Terri L. Tope, ANP
☐ Another health care provider name here**:**____

PROVIDE TO

Who do you want the patient information to be sent to?
Name:____**Phone Number:**____________________
How do you want the medical information to be sent?
☐ It will be picked up.
☐ Fax to**:**
☐ Mail to this address: ____
☐ Other (describe)**:**____
*Sending information by Fax increases privacy risks, as they involve increased risk of accidental disclosure. Information sent electronically may also be vulnerable to cyber-attack.

REQUESTED INFORMATION

Please check or describe the health information that you would like disclosed:

☐ Complete Record	☐ Discharge Summaries	☐ History & Physical Exams
☐ Consultations	☐ Physician Reports	☐ Radiology & Imaging Reports
☐ Medications Records	☐ Pathology Reports	☐ Laboratory Results

☐ Records for the following dates or treatment**:**____
☐ Other**:**____
Specific Sensitive Information needs to be <u>initialed</u> to be disclosed:
___Mental/Behavioral Health Treatment___Drug/Alcohol Abuse___HIV/AIDS Information___STD Treatment

PURPOSE

Why are you requesting this disclosure?
☐Personal Use Legal Insurance Continuation of Care Second Opinion Other**:**________________

VALIDITY

Expiration: This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here:___/___/___**Revocation:** An authorization may be revoked at any time by written notice to Alaska Digestive and Liver Disease Management. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.

PATIENT RIGHTS

I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse to sign this authorization - ADLD may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or copy my health information. I may arrange to inspect or copy information maintained by ADLD by contacting Health Information Management. I may be charged a reasonable fee for copying costs.

REQUESTOR

I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original.

Signature:____**Date:**_____ ____ ____
Print Name:____
Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Legally Authorized Representative ☐ Other: __________

OFFICE USE ONLY: Verification Method:________________ □ Priority or □ Archive
Sent by: □ PU □ Mail □ Fax □ Email □ Other:____________________Date Sent:_____/_____/_____Staff Initials:_________