CDIN Comprehensive Digestive Institute of Nevada

OFFICE AND FINANCIAL POLICY

Thank you for choosing our practice. We are committed to providing the best possible medical care for you. In order to avoid any confusion, we ask that you read the following Office and Financial Policy carefully.

Consent for Treatment:
I consent to treatment, diagnostic, and/or therapeutic services as ordered and/or provided by the physicians and ancillary providers of Kim Chen, PLLC, dba Comprehensive Digestive Institute of Nevada and designee(s).

Insurance Billing:
Your insurance policy is a contract between you and your insurance company. It is your responsibility to provide all accurate and current information regarding insurance(s) and be aware of the benefits and coverage of the insurance plan(s). It is your responsibility to know your benefits and how they would apply to your treatment. We will bill your insurance for services that we provide; however, any account insurance allowable balance that is not paid by your insurance company will be the responsibility of you (or the guarantor listed on your insurance policy). If our office does not participate with your insurance, it will be your responsibility to file your insurance claims directly with your insurance. If you fail to notify us of an insurance change or your primary or secondary insurance information, you are fully responsible for any amount not paid by your insurance company. If you neglect to disclose an insurance that you are enrolled in, we have the right to refuse future service and you may be responsible for all charges. Please note that we do NOT accept payment from attorneys for physician services.

Some insurance plans require pre-certification, pre-authorization, or a written referral. It is the patient's responsibility to understand their insurance plan requirements and ensure that the proper authorization is obtained at least 3 days prior to the date of service. Failure to do so may result in denial by the insurance company. We cannot accept responsibility for a disputed claim. Our Pre-Cert Specialist will contact your insurance plan to see if pre-certification is required for the procedure. Please note that pre-certification is not a guarantee of payment as per your insurance company. Furthermore, we will only attempt to obtain precertification or pre-authorization for your primary insurance only.

For all services provided by our physician(s) in the hospital, we will bill your health plan. Any balance due is your responsibility.

All deductibles and co-payments will be collected in full at the time of service. We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Returned checks are charged a $25.00 administrative fee. Any account unpaid over 90 days is considered past due and will be charged a $60.00 late fee. If payment is not received, the account will be turned over to our collection agency and/or attorney, this will be subject to a charge to cover the collector's fee.

Our Billing Office can be contacted at (702)745-4232.

Medicare:
We are participating providers of the Medicare program. We will accept assignment on all the claims. Patients are responsible for meeting their annual deductible and paying co-payment. We do file with the secondary / supplemental carriers. However, if the supplementary does not pay, patients will be billed the remaining balance. I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by Comprehensive Digestive Institute of Nevada. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its agents any information needed to determine these benefits or benefits for related services.

Scheduled Appointments:
We understand that delays can happen. However, we must try to keep the other patients and doctors on time. If a patient is 20 minutes past their scheduled time, we will have to reschedule the appointment.

No-Show/Cancellation Policy:
Please notify our office at least 24 hours in advance if you are unable to keep your scheduled office appointment. If you must cancel or reschedule a scheduled endoscopic procedure or diagnostic test, we require that you call at least three working days (72 business hours) in advance. Appointments and procedure times are in high demand, and early cancellation will give another person the possibility to have access to timely care. Patients failing to cancel or reschedule their office appointment as indicated above (at least 24 hours in advance) will be billed a cancellation fee of $50 if an initial consult and $25 for a follow-up visit. Patients failing to cancel or reschedule their scheduled procedure or diagnostic test as indicated above (at least 72 business hours in advance; if your procedure or diagnostic test is on a Monday, you must give notice of cancellation to our office by Wednesday at 5:00 P.M.) will be billed a cancellation fee of $150. All fees must be paid in full prior to the scheduling of future appointments.

Phone Consultations:
After-hour phone calls are limited to urgent medical issues. All other medical matters (including test results) must be discussed in the office. It is the patient's responsibility to follow-up for any results. Calling the doctor after hours or requesting phone consultation will sometimes result in a charge which insurances may not pay--making you responsible if your insurance does not cover telemedicine service provided by our practice. Charges vary depending on length of phone conversation: 1-15 minutes--$50.00, 16-30 minutes--$75.00. If you have not been seen in our office for over a year and have urgent medical issues, you need to go to the emergency room for care.

Administrative Fees:
All medical record requests are subject to a preparation fee. Please allow up to 7 working days to complete the request. A fee of $100 will be collected for completing and returning administrative forms and tasks(i.e. FMLA, disability, peer review with your insurance etc).

Acknowledgment and Authorization:
I have read, understand and agree to abide by the above Office and Financial Policy.

/

MY SIGNATURE ACKNOWLEDGES RECEIPT OF THIS FORM / DATE

CDIN | Comprehensive Digestive Institute of Nevada

PATIENT REGISTRATION

www.nevadagastro.com

office 702-483-4483 fax 702-410-6670

PATIENT INFORMATION

O Male
O Female

patient name: LAST, FIRST

address: STREET CITY STATE ZIP

phone: HOME CELL WORK email

DOB SSN

EMPLOYER INFORMATION

Employer

address: STREET CITY STATE ZIP

INSURED PERSON

(*if not patient*)

name: LAST, FIRST relation to patient phone

EMERGENCY CONTACT

name: LAST, FIRST relation to patient phone

INSURANCE INFORMATION

#1 PRIMARY INSURANCE CO. ID #

#2 SECONDARY INSURANCE CO. ID #

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

SIGNATURE **DATE**

I hereby authorize CDIN to apply for benefits on my behalf for covered services rendered by the medical providers that belong to CDIN. I request that payment from my insurance company be made directly to CDIN (or to the party who accepts assignment). I fully certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

SIGNATURE **DATE**

Prescription Refills

Please call your pharmacy for medication refills a minimum of 3 days before you will be out of your medication and as early in the day as possible to allow our staff time to review your records and obtain approval from the doctor. Please have your pharmacy fax the refill request to our office. Please note that if your insurance requires additional information in order to fill the requested medication this will cause a delay in getting your medication. Please call the pharmacy to check if a refill has been called in before calling the office back. (Please allow 72 business hours.) We DO NOT REFILL ANY prescriptions AFTER HOURS or on WEEKENDS.

_____

Initials

Phone Calls

If you need to contact our office for any medical problems, questions, test results, scheduling, or any other issue related to your care, please leave your name (with the spelling of your last name), date of birth, phone number, and a detailed message. If you are calling for an appointment, please call our main number and follow the prompts to leave a message for a scheduler. If you are calling for a medical issue, please leave a message for one of our nurses or medical assistants. Please be advised that our office has a high call volume, and that we will make every attempt to call you back in a timely fashion. Messages are checked throughout the day. If your call is received by 4:00pm, it will be returned within 24 business hours. Please do not leave multiple messages, as this only delays us in calling patients back. Thank you in advance for your patience.

_____

Initials

Multiple Appointment Cancellations or Multiple Re-Scheduled Appointments

For patients who have had multiple appointment cancellations or multiple re-scheduled appointments may result in termination from our practice.

_____

Initials

Medication Prior Authorizations

Comprehensive Digestive Institute of Nevada practices prudent and—within reason— cost-effective medicine. When generic or insurer-preferred medications are clinically appropriate and meet treatment guidelines, such option will be prioritized. If you failed the initial low-cost treatment, or if a low-cost choice isn’t appropriate, then a costlier treatment can be considered. If a prior authorization is necessary for the costlier drug, our practice will attempt to obtain the prior authorization approval initially. However, if the prior authorization request is denied by your insurance, you will need to communicate with your insurance directly regarding this denial and proceed with an appeal if you desire.

_____

Initials

CDIN Comprehensive Digestive Institute of Nevada

www.nevadagastro.com
office 702-483-4483 fax 702-410-6670

PATIENT MEDICAL HISTORY

Patient Name _____
Referring Physician _____

Reason for visit: _____

Have you ever seen another gastroenterologist for this problem? □ No □Yes
If yes, who, where? _____
Have you been admitted to the hospital or presented to the ER recently? □ No □ Yes

Pharmacy Name & Address:

_____

MEDICAL HISTORY—Check ALL past or present illnesses

GASTROINTESTINAL
□ IBS (Irritable Bowel Syndrome)
□ GERD/Heartburn
□ Barrett's Esophagus
□ Diarrhea
□ H. pylori infection
□ Peptic Ulcer Disease
□ Colonic polyp
□ Hemorrhoids
□ Diverticulosis/Diverticulitis
□ Bowel obstruction
□ Gallstones
□ IBD- Crohn's disease
□ IBD-Ulcerative Colitis
□ Pancreatitis
□ Chronic constipation
□ Gastrointestinal Bleeding
□ Stomach polyp

LIVER
□ Hemochromatosis
□ Cirrhosis
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Liver cyst
□ Fatty Liver

CANCER
□ Colon Cancer
□ Esophageal Cancer
□ Stomach Cancer
□ Breast Cancer
□ Pancreatic Cancer
□ Endometrial Cancer
□ Prostate Cancer
□ Liver Cancer
□ Leukemia/Lymphoma

OTHER_____

MUSCULOSKETAL
□ Fibromyalgia
□ Rheumatoid Arthritis
□ Raynaud's
□ Lupus
□ Sjogrens
□ Scleroderma
□ Gout

PSYCHOLOGICAL
□ Bipolar
□ Anxiety
□ Depression
□ OCD
□ Schizophrenia

HEART
□ High Blood Pressure
□ Heart Attack
□ Angina
□ Congestive Heart Failure
□ Palpitations
□ Mitral Valve Prolapse
□ Elevated Cholesterol
□ Heart valve disease
□ Endocarditis

BLOOD
□ Von Willebrands'
□ Hemophilia
□ Bleeding or clotting

RENAL
□ Kidney Stones
□ Kidney Failure
□ Dialysis

NEUROLOGICAL
□ Stroke
□ Seizures
□ Migraines
□ Other Headache

RESPIRATORY
□ COPD (Emphysema)
□ Asthma
□ Tuberculosis
□ Sleep Apnea
□ Collapsed Lun

ENDOCRINOLOGY
□ Diabetes Type I (insulin needed)
□ Diabetes Type II (oral medications needed)

□ Hyperthyroidism
□ Hypothyroidism
□ Hyperparathyroidism

INTEGUMENTARY
□ Skin Cancer
□ Melanoma
□ Psoriasis
□ Vitiligo
□ Eczema

MEDICATIONS List ALL prescriptions, supplements, and over the counter medications

Medication	Medication
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

ALLERGIES

□ No Known Drug Allergies □ Iodine □ Sulfa □ Aspirin □ Penicillin □Other: _____

ISSUES WITH ANESTHESIA: □ Yes □ No If yes please explain _____

SURGICAL HISTORY: Please list below

_____ _____

_____ _____

_____ _____

FAMILY HISTORY: Check ALL diseases that have occurred in your family and indicate family member affected

□ Crohn's Disease
□ Irritable Bowel Syndrome
□ Ulcerative Colitis
□ Liver Disease
□ Colon Polyps
□ Stomach Cancer
□ Esophageal Cancer
□ Pancreatic Cancer
□ Colorectal Cancer

OTHER: _____

EVALUATION HISTORY

Have you ever had upper endoscopy? □ Yes □ No If yes please explain date and finding _____

Have you ever had colonoscopy? □ Yes □ No If yes please explain date and finding _____

Have you ever had abdominal CT scan? □ Yes □ No If yes please explain date and finding _____

GENERALIZED REVIEW OF SYMPTOMS Check ALL that apply

CONSTITUTIONAL

□ Decreased appetite
□ Excessive fatigue
□ Night Sweats
□ Weight Loss

CARDIOVASCULAR

□ Irregular heartbeat
□ Leg swelling
□ Poor exercise tolerance
□ Chest Pain

ENDOCRINE

□ Excessive thirst
□ Cold intolerance
□ Menopause
□ Weight gain(10+ lbs)
□ Weight loss

PSYCHIATRIC

□ Trouble Sleeping
□ Depression

NEUROLOGICAL

□ Dizziness
□ Headaches
□ Numbness/Tingling
□ Seizures

MUSCULOSKELETAL

□ Back pain
□ Recent injury
□ Swelling

HEMATOLOGICAL

□ Anemia
□ Bleeding and/or bruising
□ Blood transfusion

URINARY

□ Frequency of urination
□ Loss of bladder control
□ Burning with urination

EYES, EARS,NOSE,THROAT

□ Dentures/Partials
□ Ear pain/Ringing
□ Eye pain/Blurred vision
□ Hearing loss
□ Hoarseness
□ Inability to smell
□ Neck Lumps

SKIN

□ Bruising
□ Itching
□ Jaundice
□ Rash
□ Skin cancer
□ Tattoo

RESPIRATORY

□ Chronic cough
□ Sleep Apnea
□ Shortness of breath
□ Wheezing/Asthma

GI REVIEW OF SYMPTOMS Are you currently experiencing any of the following symptoms?

Abdominal Pain, if yes, for how long?_____

□ Intermittent (on and off)
□ Constant
□ Burning
□ Sharp
□ Cramping

□ Dull Ache
□ Better with food
□ Worsened with food
□ No effect with food
□ Relieved by bowel movement

□ Relieved by passing gas
□ No relief with bowel movement or passing gas
□ Other _____

Severity: 1 (mild) – 10 (severe)? _____
What improves the pain? _____
What worsens the pain? _____

Bloating If yes, for how long?_____

Heartburn, If yes, for how long? _____

Diarrhea, if yes, for how long? _____

□ Recent Travel
□ Antibiotics in the past 3 months

Rectal Bleeding, if yes, for how long? _____
□ Bright red blood □ Blood mixed in stool □ Blood on toilet paper

Constipation, if yes, for how long?_____
□ Number of bowel movements per week?_____
□ Remove stool with finger sometimes
□ Require laxatives or enemas frequently
□ Sense of incomplete emptying

Food stuck in esophagus, if yes, for how long? _____
□ Liquids □ Solids □ Both

Vomiting, if yes, for how long? _____
□ Food □ Bile (green)

Recent changes in bowel habits, □ Yes □ No If yes, for how long? _____

Fecal incontinence □ Yes □ No If yes, for how long? _____

CDIN | Comprehensive Digestive Institute of Nevada

Authorization for Communication of Protected Health Information to Family Members and Friends

1. I authorize Comprehensive Digestive Institute of Nevada to discuss/share protected health information about me with the following individual(s) who are involved in my care:

NAME:	RELATIONSHIP:	PHONE NO.:
NAME:	RELATIONSHIP:	PHONE NO.:
NAME:	RELATIONSHIP:	PHONE NO.:

This authorization shall remain in effect until revoked in writing by the patient.

Submitting a new form will revoke existing form.

X_____ X_____

SIGNATURE OF PATIENT/AUTHORIZED INDIVIDUAL DATE

E-Mail to: info@nevadagastro.com

Fax to: 702-410-6670