NORTH VALLEY G.I. CONSULTANTS

PATIENT INFORMATION

Gender: ❑ Male ❑ Female **Marital Status**: ❑Single ❑Married ❑Divorced ❑Widow **PROVIDE AT LEAST LAST 4 DIGITS**

First _____ MI____ Last _____ Birthdate_____SS#_____

Address _____City_____State_____Zip Code _____

Home Phone (_____)_____Cell Phone (_____) _____

I authorize for you to send E-mail to me at the following address: _____

Preferred Contact Method: *(check one)* ❑ Home Phone ❑ Cell Phone ❑Work Phone ❑Address ❑E-mail

NOTICE: These questions are Included to comply With new federal Health guidelines We are required to Ask all patients for This information.

ETHNICITY: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Declined

RACE : ❑White ❑American Indian/Alaska Native ❑Asian ❑Black/African American ❑Hispanic ❑ Native Hawaiian/other Pacific Islander ❑Declined ❑Other_____

PREFERED LANGUAGE: ❑ENGLISH ❑SPANISH ❑JAPANESE ❑ITALIAN ❑PORTUGUESE ❑ RUSSIAN ❑BOSNIAN ❑ VIETNAMESE ❑ CHINESE ❑ GUJARATI ❑ HINDI ❑ LOATIAN ❑ GERMAN ❑ ARABIC ❑FRENCH ❑ TAGALOG ❑DECLINED ❑OTHER_____

Referred to this office by: _____ Phone: (_____)_____

Primary Care Physician: _____ Phone: (_____)_____

Pharmacy Name: _____Address:_____Phone: (_____) _____

Emergency Contact Name _____Relationship_____ Phone (_____)_____

Patient Employment Information

❑Full-Time ❑Part-Time ❑Student ❑Retired ❑Unemployed

Employer Name: _____ Work Phone :(_____) _____

Employer Address_____City_____State_____Zip Code_____

Occupation_____

INSURANCE INFORMATION (If you are insured through someone else, please list that persons information below)

PRIMARY Ins. Name: _____ID #: _____

Group/ Policy #: _____ Ins. Phone #: (_____) _____

Subscriber's Name: _____ Subscriber's SSN: _____

Relationship to Patient: _____ Subscriber's Date of Birth: _____

SECONDARY Ins. Name: _____ID #: _____

Group/ Policy #: _____ Ins. Phone #: _____

Subscriber's Name: _____ Subscriber's SSN: _____

Relationship to Patient: _____ Subscriber's Date of Birth: _____

I certify by my signature below that I understand and agree that I am ultimately responsible for payment.
I further certify that this information is true and correct to the best of my knowledge.

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize Medicare/Insurance Company to pay directly to **NORTH VALLEY G.I. CONSULTANTS** for surgical/medical services furnished to me. I realize that this may not represent the full payment for this service rendered and I will be responsible for balance due. I hereby authorize **NORTH VALLEY G.I. CONSULTANTS** to release any medical information needed by my insurance company.

Patient Signature/ Responsible Party_____ Date: _____

1156 Swallow Ln. | Simi Valley | CA 93065 | Phone 805.526.6016 | Fax 805.791.3992

NORTH VALLEY G.I. CONSULTANTS

Name:_____ **Date:** _____

Referring Doctor: _____

Present Complaints:_____

PAST MEDICAL HISTORY

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

___ Liver Disease	**___Rheumatic Fever**	**___Heart Attack**	**____COPD**
___Anemia	**___Epilepsy (Seizure)**	**___Kidney Disease**	
___Arthritis	**___Venereal Disease**	**___Stroke**	
___Asthma	**___Colon Polyp**	**___Ulcer**	
___Diabetes	**___High Blood Pressure**	**___ Cancer _____**	
___Emphysema	**___High Cholesterol**	**___ Jaundice**	
___ Hypothyroidism	**___Anxiety**	**___ Sleep Apnea**	**_____ CPAP Machine**

Other: _____

Surgery (Operations): _____

History of anticipated intolerance to standard sedatives?_____

HABITS

Smoke: ___YES___NO If yes, How many per day? _____ How long? _____ When Stopped? _____

Alcohol? ___YES___NO If yes, Type _____ Amount? _____How long? _____ When Stopped? _____

Exercise: ___Yes___NO if yes, Type_____ How frequent? _____ Coffee? (#of cups daily) _____

Drug Abuse? ___Yes___NO if yes, Type? _____How long? _____ When Stopped? _____

Blood Thinners, Steroids or Cortizone? _____ YES _____ NO

FAMILY HISTORY

	FATHER	MOTHER	SIBLINGS	CHILDREN	MOTHER'S PARENTS	FATHER'S PARENTS
HYPERTENSION						
STROKE						
CANCER						
DIABETES						
ULCER						
BLEEDINGDISORDER						
KIDNEY DISEASE						
HEART DISEASE						
OTHER						

_____

ANY OTHER INFORMATION WHICH YOU MAY FEEL MAY BE HELPFUL:

_____

_____

_____

NORTH VALLEY G.I. CONSULTANTS
MEDICATION LIST

PATIENT NAME: _____ **DATE:** _____

MEDICATION	DOSE	FREQUENCY	START DATE	END DATE	PRESCRIBER	REASON

MEDICATION ALLERGIES:

LATEX? ____ YES ___NO

NORTH VALLEY G.I. CONSULTANTS

Gastroenterology, Pancreatic, Biliary & Liver Disease
ERCP, Capsule Endoscopy

Mahendra N. Patel, M.D.
Diplomat American Board of Internal Medicine
Internal Medicine & Gastroenterology

Robert B. Moghimi, M.D.
Diplomat American Board of Internal Medicine
Internal Medicine & Gastroenterology

AUTHORIZATION TO PAY BENEFITS

I hereby authorize MEDICARE and/or INSURANCE payment be made directly to North Valley G.I. Consultants for surgical and/or Medical services.

I realize that the Medicare/Insurance may not represent full payment for rendered services and I am responsible for the balance due.

I hereby authorize North Valley G.I. Consultants to release information concerning my illness to the insurance carrier.

_____ _____

Signed (Patient or Legal Guardian) **Date**

_____

Medicare Number / Insurance Number

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Gastroenterology, Pancreatic, Biliary & Liver Disease
ERCP, Capsule Endoscopy

Mahendra N. Patel, M.D. **Robert B. Moghimi, M.D.**

CANCELLATION POLICY/ NO SHOW POLICY FOR DOCTOR SURGERY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment,. Please remember that in order to accommodate another patient in you r place we must notify the patient at least 5 days prior to the procedure to make arrangements and prepare for his/ her surgery.

1. Cancellation/ No Show Policy For Surgery
   Due to the large block time needed for surgery, last minute cancellation can cause problems and added expenses for the office and/or facility.
   If the surgery is not cancelled at least 5 days in advance you will be charged seventy five dollars ($75.00) fee; This will not be covered by your Insurance .

2. Account Balances
   We will require that patients with self pay balances pay their account balance to zero (0) prior to receiving further services by our practice.
   Patients who have questions about their bills or who would discuss payment plan options may call and ask to speak to our buisness office representative with whom they can review their account and concers.
   Patients with balance over $100.00 must make payment arrangements prior to future appointment being made .

_____ _____ _____ /____/_____
Print Name (Patient) Signature Patient/ Guardian Date

Patient Account# _____

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Phone: (805)526-6016 Fax: (805)791-3992

P210B ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name: **Home Phone:**

Address: **City/State/Zip:**

I have received the Notice of Privacy Practices / He recibido el Aviso de Politicas de Privacidad

Signature/ Firma: _____ **Date/Fecha:** _____
Patient/Spouse/Financially Responsible Party

Relationship, If other than Patient: ❑ Parent ❑Child ❑Sibling ❑ Guardian ❑other:_____

Patient refuses, or is unable, to acknowledge receipt of the Notice of Privacy Practice

Employee Signature: _____ **Date:**_____

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P210A NOTICE OF PRIVACY PRACTICES

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

NOTICE APPLIES TO

This Notice describes the practices of this office and those of:

- Any healthcare professionals authorized to enter information into your record;
- All employees, staff and other office personnel; and
- Any volunteers, interns, or students we allow to work with you while you are a patient of this Medical Practice.

This Notice applies to all facilities and entities owned. Operated and/or managed by this practice. A complete listing of facilities and entities operating under this notice may be obtained by contacting the Privacy Officer at (818)363-7120.

THE DUTIES OF THIS OFFICE /ORGANIZATION

This office/organization is required by law to maintain the privacy of your personal medical information and to provide you with notice of our legal duties and privacy practices with respect to that information. We are also required to abide by the terms of our current Notice of Privacy Practices.

USE AND DISCLOSURE OF MEDICAL INFORMATION

The office/organization my use your medical information for treatment, payment, and healthcare operations purposes. The following are some examples:

- For treatment purposes, we may release your medical information to other physicians, dentists, or health care providers, such as nurses or technicians, to assist in treating you.
- In billing for your treatment, we may release your medical information to your insurance company in filing claim or in order to receive payments.
- We may also use your medical information for our healthcare operations. This includes activities involving review of our treatment and services to help us evaluate the quality of care we are providing, and evaluation of the performance of our staff in caring for you.

APPOINTMENT REMINDERS, CALL BACKS, & TREATMENT ALTERNATIVES

We may use your information to contact you for appointment reminders, to call you with the results of diagnostic tests, or to check on your condition following a visit or procedure. We may also contact you to provide you with information about treatment alternatives or health-related benefits or services.

FUNDRAISING

We may use your information to contact you in effort to raise money for this organization and its operations.

OTHER DISCLOSURES

There are some disclosures of medical information that do not require your authorization. Those disclosures include any of the following:

- Those required by federal, state or local law;
- To report adverse events or defects associated with products or medications;
- For public health activities, such as the reporting of communicable diseases;
- About victims of abuse, neglect or domestic violence;
- To comply with government oversight activities, such as audits or investigations;
- For organ or tissue donation purposes, if you are an organ donor;
- For Judicial or administrative proceedings;
- For specialized government functions, such as intelligence, counter-intelligence, or other national security activities; and
- For worker's compensation.
- For law enforcement purposes, such as in the course of a crime investigations or location of a missing person;
- Other uses and disclosures of your medical information will be made only with your specific written authorization, which you may revoke any time by giving written notice.

YOUR RIGHTS

You have the following rights regarding the medical information we maintain about you:

- You have the right to request restrictions on use and disclosure of your medical information, and you have the right to request a limit on the information we disclose about you to someone who is involved in your care or your payment for your care, such as a family member or friend. We are not required to agree to the restriction, but once we do agree, we are bound by that agreement, unless the information is needed to provide you with emergency treatment.
- You have the right to receive communication of your medical information. Request must be made in writing and an appropriate charge may be assessed for each page copied.
- You have the right to inspect and obtain copies your medical information. Request must be made in writing and an appropriate charge may be assessed for each page copied.
- You have the right to request a change to your medical information if you believe there is an error. You must submit a request in writing; including the information you believe should be changed and we will change your record, if appropriate. We reserve the right to deny the request to change your record, if the change is not appropriate.
- You have the right to a list of disclosures we have made of your medical information, excepting disclosures made for the purpose of treatment, payment and healthcare operations. Requests must be made in writing. You may receive one listing per calendar year without charge; any additional listings may be subject to a reasonable fee.
- You have the right to receive a paper copy of this notice upon request.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have any questions about this Notice, please contact our Privacy Officer at (818)363-7120.

If you believe that we have violated your right to privacy, you may complain to the Privacy Officer at (818)363-7120, or to the Secretary of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. There will be no retaliation for filing a complaint.

We reserve the Right to change our health information practices and the terms of our Notice of Privacy Practices, and to make the changes effective for all protected health information we maintain, including health information created or received before the effective date of the changes. In the event we change our health information practices, we will post and/or personally provide a revised Notice of Privacy Practices.

EFFECTIVE DATE

This Notice is effective as of April 14, 2003.