Monterey Bay G.I. Consultants Medical Group Inc.
Monterey Bay Endoscopy Center LLC

Last Name: _____ Gender: ☐ Male ☐ Female

First Name: _____ Home Phone: (_____)_____ - _____

Middle Initial: _____ Cell Phone: (_____)_____ - _____

Birth date: _____/_____/_____ Okay to text you important messages? ☐ Yes ☐ No

Social Security Number _____ - _____ - _____ Work Phone: (_____)_____ - _____

Mailing Address: _____ Do you wish to be invited to our portal? ☐ Yes ☐ No

_____ E-Mail Address: _____

City: _____ State: _____ Contact Preference:
☐ Home ☐ Cell ☐ Work

Zip Code: _____

Marital Status:
☐ Married ☐ Single ☐ Divorced
☐ Separated ☐ Widowed ☐ Partner

Driver's License #: _____ Preferred Language: _____

Employer: _____ Race: _____

Occupation: _____ Ethnicity: _____

Emergency Contact: _____ Phone: _____
Name/Relation

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy: _____ Street/City: _____

Preferred Lab: _____ Street/City: _____

INSURANCE INFORMATION

Primary: _____ Secondary: _____ Tertiary: _____

Please provide all insurance cards to the receptionist upon check-in with your driver's license.
If you have Medicare Part D or a prescription card, please provide that card to the receptionist.

By signing below I certify that the information I have provided above is correct.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient Signature: _____ Date: _____

Monterey Bay G.I. Consultants Medical Group Inc.
Monterey Bay Endoscopy Center LLC

OFFICE POLICIES

RELEASE OF HEALTH INFORMATION

I consent to treatment for the care of the patient below. I authorize the release of all medical information to my referring and primary care physicians, as well as to the insurance carriers, as needed, to process a claim.

PAYMENTS

It is the policy of this office to collect full payment, deductibles and co-payments at the time of service. Physician and facility charges will be billed to you unless insurance information is provided to our office before the time of service. I request insurance payments of medical benefits be made directly to the medical provider and/or the facility provider. I understand that I am financially responsible for all charges and that I will be expected to pay if my insurance has not paid within 90 days from the date of service. If a credit card is used for payment of any service, I authorize any overpayment to be returned to the same credit card.

PAYMENTS FOR PROCEDURES

If you are scheduled to have a procedure(s), our billing office can provide you with the best estimate of charges, however, due to the nature of and until the procedure(s) are performed, it is not possible to quote the exact amount. Our billing office will call your insurance company to obtain authorization, if required, and an estimate of the portion that is your financial responsibility. *Pre-authorization is not a guarantee of payment.*

INSURANCE

You are responsible to contact your insurance prior to services to determine if an authorization is requested. Failure to obtain authorization will result in you being responsible for the services provided. As a courtesy to our patients, we will bill your primary and secondary insurance carriers. We do not guarantee that your insurance will cover our services. It is your responsibility to keep our office updated with your most current insurance information and to verify that you have coverage for services provided by our office. We are contracted providers for most insurance carriers. We recommend that you verify this information prior to being seen in our office. An itemized statement will be sent to you after your insurance has processed your claim for services. If your insurance has not processed your claim within 45 days, we reserve the right to bill you for the full balance.

WHAT ARE MY OPTIONS IF I DO NOT HAVE INSURANCE?

Full payment is due at time of service. If you do not have insurance and cannot pay your balance in full, a patient account representative is available to discuss payment options and/or assist you with a payment plan. You can reach a representative at 831-375-3577, Option #5.

RETURNED CHECKS POLICY/NON-PAYMENT OF SERVICES

Checks returned to our office for insufficient funds are subject to a $25 service charge. Every effort will be made to work with our patients on an affordable and reasonable payment plan; however, we reserve the right to send an account with a balance over 90 days old to an outside collection agency. If it becomes necessary to send an account to collection, the patient may be discharged from the practice.

CANCELLATION AND MISSED APPOINTMENT POLICY

"No-Shows" and "Late Cancellations" cause problems that go beyond a financial impact on our practice. When an appointment is missed, that available time is lost for another patient.

Office Visits: $50 fee will be charged for each no-show or late cancellation, if notice is given less than **24 business hours.**
Procedures: $200 fee will be charged for each no-show or late cancellation, if notice is given less than **48 business hours.**
Business hours are: Monday - Friday, between 8:30 am and 5:00 pm, except holidays.

I have read and understand the terms of these policies. I agree to comply with the terms set forth in these policies for services rendered by Monterey Bay GI Consultants Medical Group Inc. and/or the Monterey Bay Endoscopy Center LLC.

_____
Patient Name

_____ _____
Patient Signature **Date**

Monterey Bay G.I. Consultants Medical Group Inc.
Monterey Bay Endoscopy Center LLC

NOTICE OF HEALTH INFORMATION 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.

OUR DUTIES

We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. A copy of this notice will be available at any of our offices, from our Privacy Officer by calling (831) 375-3577, or by writing to Monterey Bay GI Consultants Inc or Monterey Bay Endoscopy Center LLC, 23 Upper Ragsdale Drive, Monterey, CA 93940. You may also address questions regarding our privacy practices, your privacy rights, or requests for additional information regarding your privacy to this person.

PERMITTED USES AND DISCLOSURES

Federal Law allows us to use and disclose your medical information in the ordinary course of providing healthcare services to you. We have described some of these uses and disclosures in the following paragraphs:

Treatment

We will provide to your other healthcare providers the minimal information they need to treat you. We may contact you before an appointment or talk to you about preparing for an appointment or a procedure. We will try to contact you at the phone numbers you have given us. If you are not available and your voice mail answers, we may leave a brief message to remind you of the place and time of your appointment. We may ask you to call us regarding specific medical information concerning your case. We will not leave your test results or your diagnosis on your voice mail machine.

Payment

We may need to contact your health plan for the purpose of billing your account or to pre-authorize the exams, procedures or tests your doctor has ordered. We may have to release details of your medical information, if your health plan or other payer requires this information to make payment. If you do not want this information released to your payer, then you must pay your bill in full at the time of service and inform us not to bill anyone else.

Health Care Operations

We often have to use specific patient information to conduct our normal business operations. We may have to look at the information in the doctor's reports in order that we may fill out forms on your behalf. We may use your medical record to review our treatment and services and to evaluate the performance of our staff in caring for you.

DISCLOSURES WITHOUT AUTHORIZATION

We may use and disclose medical information about you, without your specific authorization, as follows:

Disclosures Required by Law

We may be required by federal, state, or local law to disclose your medical information.

Public Health Activities

We may disclose your medical information to a public agency, such as the Food and Drug Administration (FDA), if you experience an adverse effect from any of the drugs, supplies, or equipment we use.

Victims of Abuse, Neglect, or Domestic Violence

We may be required to disclose your medical information if we feel that you have been abused or neglected.

Judicial and Administrative Proceedings

We may have to disclose your medical information if we receive a subpoena from a judge or administrative tribunal.

Law Enforcement

We may have to disclose your medical information in conjunction with a criminal investigation by a federal or state law enforcement agency.

Serious Threats to Health or Safety

We may be required to disclose your medical information if, in our opinion, doing so will help avert a serious threat to the public.

Military Personnel

We may disclose your medical information to the appropriate command authorities.

Worker's Compensation

We may disclose your medical information to comply with laws regarding worker's compensation.

Monterey Bay G.I. Consultants Medical Group Inc.
Monterey Bay Endoscopy Center LLC

PATIENT RIGHTS

You have certain rights with respect to your medical information. Federal law allows us to use and disclose your PHI for treatment, payment and health care operations. We are required by the U.S. Department of Health & Human Services to ask you to sign an authorization. Therefore, the first time you see one of our physicians or health care providers, we will ask you to sign a consent form allowing us to use and disclose your personal information in conjunction with your treatment, payment for treatment and our healthcare operations.

Requesting Restrictions

You may ask us to limit our use or disclosure of your protected health information. We are not required to agree to your request, but if we agree to it, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. Your request must: 1) be in writing, 2) describe the information that you want restricted, 3) state if the restriction is to limit our use or disclosure, and 4) state to whom the restriction applies. You may revoke your restriction at any time by contacting our Privacy Officer. We may ask to reschedule your exam while we consider your request.

Confidential Communications

You may ask that we communicate with you in a particular way, or at a certain location to maintain your confidentiality. Your request must be in writing. It must tell us how you intend to satisfy your financial responsibility, and specify an alternate way that we can contact you confidentially. You do not have to give a reason for your request. You may revoke your request at any time by contacting our Privacy. We may to reschedule your exam while we consider your request.

Inspect and Copy

You may request access to inspect and copy your medical information maintained in our records, including billing records. Your request must be in writing. We will act on your request for inspections within 5 working days after we get the request. We will act on your request for copies with 15 days after we get the request. We will send you a written denial. If this happens, you may request a review of the denial. We will send you a bill for the copies. If you want to know the charges in advance, you may request it. If you have a dispute over the bill for copying you will need to dispute it with the copy service. The copies may be picked up in one of our offices at your request, or they may be mailed to you.

Amendment

You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if we believe that the information is complete and accurate, if the information is not part of the medical information that you would be permitted to inspect or copy, or if we did not create the information. You also have the option of submitting your own amendment.

Accounting of Disclosures

You may request a list of non-routine disclosures that we have made of your medical information. This does not include disclosures we make for your treatment, to seek payment for our services, or for our normal business operations or for those you authorize in writing. Your first request within a 12-month period is free, but we may charge for additional lists within the same 12-month period.

File a Complaint

If you believe that we have violated your privacy rights, you may file a complaint directly with our Privacy Officer. You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not penalize you for complaining.

PATIENT AUTHORIZATIONS FOR CERTAIN DISCLOSURES

We will request your written authorization for uses and disclosures of your medical information that we did not identify in this notice or for those not otherwise permitted by law. You may revoke your authorization in writing at any time by contacting our Privacy Officer. You may request a copy of your authorization at any time.

Monterey Bay GI Consultants Medical Group, Inc.
Dr. Michael Le
NEW PATIENT QUESTIONNAIRE
(To be filled out at first visit or if patient has not been seen in over 3 years)

NAME: **Age:** **Date of Birth:**

REASON for your visit today: _____
Which doctor referred you to see us today? _____
Who is your PCP (Primary Care Physician) if not the person listed above? _____

YOUR PAST MEDICAL HISTORY: Please CIRCLE all that applies to you:

HEART DISORDER: • Previous heart attack • Metal stents in your back • Coronary artery bypass surgery • Mechanical heart valve • Atrial Fibrillation • Congestive heart failure • Pacemaker or defibrillator	**DIGESTIVE DISORDER:** • Acid reflux (heartburn) • Stomach ulcers • H. pylori infection (in your stomach) • Pancreatitis (inflammation of the pancreas) • Irritable Bowel Syndrome (IBS) • Inflammatory Bowel Disease (IBD) (e.g. Chron's disease, Ulcerative Colitis) • Lactose intolerance (dairy products causes diarrhea, bloating)
BREATHING DISORDER: • Asthma • COPD (Chronic Obstructive Pulmonary Disease) • Interstitial lung disease • Sleep Apnea / use CPAP machine	**LIVER DISORDER:** • Previously known abnormal liver function test • History of alcoholism • Hepatitis B • Hepatitis C • Fatty liver disease • Cirrhosis
OTHER PROBLEMS: • Hypertension (high blood pressure) • Diabetes Mellitus • High cholesterol • Obesity • Previous stroke • Kidney disease • Thyroid disease (hypothyroidism, hyperthyroidism) • Arthritis • Anxiety requiring medication • Depression requiring medication • Chronic pain requiring pain medication	**BLEEDING DISORDER:** • Anemia (low blood counts) • Heavy menstrual periods • Hemophilia • **KNOWN HISTORY OF MALIGNANCY:** • Esophageal cancer • Stomach cancer • Small bowel cancer • Colon cancer • Lung cancer • Breast cancer • Prostate cancer • Lymphoma/Leukemia • Other:

YOUR PAST SURGICAL HISTORY: Please **CIRCLE** all that applies to you:

• **Colonoscopy** – If yes, when? • **Upper Endoscopy (EGD)** – If yes, when?	• Surgery on your esophagus • Radiation to the chest • Stomach surgery (such as weight loss surgery) • Gallbladder removal • Small bowel surgery • Colon surgery • Uterus removal (hysterectomy)	• Ovaries removal (oophorectomy) • Cesarean section • Bladder surgery • Prostate surgery or prostate radiation • Known implanted metal in your body • List any other surgeries not mentioned:

Please CIRCLE any CURRENT SYMPTOMS you are having:

- **"Heartburn" = burning sensation, acid taste**
- **Chronic nausea**
- **Chronic vomiting**
- **Vomiting blood or "coffee ground like material"**
- **Difficulty swallowing**
- **Upper abdominal pain**
- **Lower abdominal pain**
- **Diarrhea**
- **Constipation**
- **Bloating and gassiness**
- **Rectal pain**
- **"Black tar-like" stools**
- **Blood in your stools (Maroon? Bright red blood?)**
- **Unintentional weight loss**
- **Your symptoms wake you up at night**
- **Significant fatigue**
- **Significant weakness**
- **Fever or chills**
- **Headaches**
- **Blurry vision**
- **Chest pain**
- **Shortness of breath**
- **Cough**
- **Rash**
- **Uncontrolled itching**
- **"Yellowing" of the eyes**
- **Joint pain, (if so where?)**
- **Significant leg swelling**
- **Pain with urination**
- **Currently depressed**
- **Insomnia**

YOUR FAMILY HISTORY: Circle all that applies and list WHO in your FAMILY has the following?

- Family history of esophageal cancer
- Family history of stomach cancer
- Family history of small bowel cancer
- Family history of colon cancer
- Family history of lymphoma
- Family history of liver disease or liver cancer
- Family history of Diabetes
- Family history of stomach cancer
- Family history of H. pylori infection
- Family history of Celiac disease
- Family history of Inflammatory Bowel Disease (Crohn's disease or Ulcerative Colitis)
- Family history of heart disease

NONE (If no family member has any of the above)

YOUR SOCIAL HISTORY:

Occupation: _____
Marital status: Single / Married / Divorced / Widowed Number of Children: _____
Alcohol: Yes / No If yes, number of **drinks per day/week** _____ for **how many years** _____
Tobacco: Yes / No If yes, how many **packs per day/week** _____ for **how many years** _____
History of **intravenous drug use, cocaine, marijuana, or other illicit drugs**? Yes / No - If yes, last used:

Tattoos: Yes / No If so are they homemade or obtained at a parlor?
Required a blood transfusion in the past: Yes / No

WHAT DRUGS ARE YOU ALLERGIC TO? _____

CURRENT MEDICATIONS: CIRCLE any of the following drugs you are taking:

You take a **"blood thinner"** such as: • Coumadin (Warfarin) • Enoxaparin (Lovenox) • Dabigatran (Pradaxa) • Clopidogrel (Plavix) You take a medication for **anxiety or sleep** such as: • Lorazepam (Ativan) • Alprazolam (Xanax) • Diazepam (Valium)	You take a medication for pain such as: • Aspirin • Tylenol • Ibuprofen • **Narcotics** such as (oxycodone, oxycontin, morphine, Percocet, Lortab, Vicodin, Norco, Fentanyl, Methadone, etc.)	List any over the counter herbal products, weight loss products, or other supplements

NEW PATIENT QUESTIONNAIRE
GENETIC TESTING

Patient Name:

Personal and Family History:

1) Do you have a first-degree relative (mother, father, brother, sister, or child) with any of the following conditions diagnosed **BEFORE AGE 50**?

Colon, rectal, or uterine cancer	Yes / No
Cancer of the ovary, stomach, small intestine, kidney, ureter, bladder, bile ducts, pancreas, or brain	Yes / No

2) Have you had any of the following diagnosed BEFORE AGE 50?

Colon, rectal, or uterine cancer	Yes / No
Colon or rectal polyps	Yes / No

3) Do you have **(3)** or more relatives with a history of colon, rectal, or uterine cancer? Yes / No

Who in you mother's side (parents, brothers, sisters, children, grandparents, aunts, uncles)?

Who on your father's side (parents, brothers, sisters, children, grandparents, aunts, uncles)?

For Office Use Only

___ Genetics Counseling Appropriate

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PATIENT MEDICATION LIST

Patient Name: _____ DOB: _____

Preferred Pharmacy & Location: _____

Mail Order Pharmacy (if applicable): _____

Are you allergic to any medications? _____Yes _____No

Please list them: _____

<u>It is very important</u> for your doctor to know about ALL of the medications you are taking. Please take the time to fill out the required information below and bring your medications with you to your visit.

NAME OF MEDICATION (Including Over the Counter)	Which doctor prescribed it?	DOSAGE (mg)	DIRECTIONS How do you take this medication? How many times per day?

If you have Medicare D or another pharmacy card, please present it to the receptionist.