



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

FINANCIAL POLICY

PAYMENTS

Full payment and/or co-payments are due at the time of service. We accept cash, check, and credit card.

PAYMENT 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. A Patient Accounts Representative will contact you by mail to inform you of your estimated portion, which is due prior to your procedure. If you cannot pay your portion in full, the account representative can discuss payment options and/or assist you with a payment plan.

INSURANCE

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 a few 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 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.

I have read and understand the terms of this financial policy. I agree to comply with the terms set forth in this policy for services rendered by Monterey Bay GI Consultants Medical Group Inc.

Patient Name

Patient Signature

Date

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Póliza Para Cita Perdida

Hacemos citas para poder ver a nuestros pacientes lo más eficientemente posible. Cita sin presentación y cancelaciones al ultimo momento causan problemas que van más allá de un impacto financiero en nuestro consultorio. Cuando hace una cita y no cancela a tiempo. (Dentro de 24 horas de la cita). Eso afecta el horario del doctor que pudo haber usado ese horario para otro/a paciente.

La definición de "cite sin presentacion" es falta a una cita o procedimiento programado.

La definición de "cancelaciones al ultimo momento" es no llamar con anticipación en los momentos adecuados que se muestran abajo.

Visita a consulta - Cuota de \$50.00 se cobrará por cada cita sin presentacion o cancelacion al ultimo momento cuando se da menos de 24 horas de oficina.

Procedimiento - Cuota de \$200.00 se le cobrará por cada cita sin presentacion o cancelacion al ultimo momento cuando se da menos de 48 horas de oficina.

Horarios de oficina son de Lunes a Viernes 8:30 am a 5:00 pm, excepto días festivos. Por favor, comprenda que las companias de seguros consideran estos cargos totalmente la responsabilidad del paciente.

Fecha

Firma de Paciente

Por Favor escriba su nombre completo



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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.



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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.

Received by patient on (date) _____

(Signature of Patient)

PRINT NAME

CUESTIONARIO PARA PACIENTE NUEVO Y ESTABLECIDO

(Requerida en la primera visita o si el paciente no a tenido cita en más de un año)

Nombre del paciente: _____ Fecha de nacimiento: _____ Edad: _____ Fecha: _____

Médico de referencia: _____ MOTIVO DE SU VISITA: _____

Alergias: _____

Historial Médico

Enfermedad de Corazón	Sí/No	Artritis	Sí/No	Problema de Tiroides	Sí/No	
Diabetes	Sí/No	Fibrilación Auricular	Sí/No	Cáncer de Colon/Rectal	Sí/No	Edad: _____
Apnea del Sueño	Sí/No	Hipertensión	Sí/No	Cáncer Uterino	Sí/No	Edad: _____
Asma	Sí/No	Colesterol Alto	Sí/No	Otro:	_____	

Sirugías pasadas: _____

Revisión del sistema

Dolor de Pecho	Sí/No
Sed Excesiva	Sí/No
Visión Borrosa	Sí/No
Micción Excesiva	Sí/No
Dolores de Cabeza	Sí/No
Depresión	Sí/No
Falta de Aliento	Sí/No
Tos	Sí/No
Escalofríos	Sí/No
Calentura	Sí/No
Dolor en las Articulaciones	Sí/No
Sarpullido	Sí/No

Antecedentes Familiares de Cáncer

	Cáncer De Colon	Cáncer Uterino	Cáncer de mama	Cáncer de Ovarios	Pólipos en el colon
Madre	_____	_____	_____	_____	_____
Padre	_____	_____	_____	_____	_____
Hermano/a	_____	_____	_____	_____	_____
Hijo/a(s)	_____	_____	_____	_____	_____
Abuelo/a	_____	_____	_____	_____	_____
Tía/Tío	_____	_____	_____	_____	_____
Primos	_____	_____	_____	_____	_____

¿Alguno de los anteriores an tenido cáncer antes de los 50 años?

¿Quien? _____ ¿Qué edad? _____

Historia Social

¿Está trabajando actualmente? _____ ¿Cuál es su ocupación? _____

Estado Civil: ___Casado/a ___Soltero/a ___Separado/a ___Divorciado/a ___Viudo/a Número de hijos: _____

Uso de tabaco: Sí/No ___Todos los días ___Algunos días ___Ex fumador ___Nunca fumador

¿Cuántos paquetes por día? _____ ¿Años de uso? _____

Consumo de Alcohol: Sí/No ¿Cuantos por día? _____ ¿Por semana? _____ ¿Por mes? _____ ¿Número de años? _____

Drogas Ilícitas: Sí/No Notas: _____

**Monterey Bay GI Consultants medical Group, Inc.
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 23 Upper Ragsdale Drive, Monterey CA 93940**

LISTA DE MEDICAMENTOS

Nombre: _____ **Fecha de nacimiento:** _____

Ubicacion y Farmacia Preferida: _____

Allergias a Medicamentos?
 Si Favor de darnos una lista: _____
 No _____

Nombre de Medicamento	Dosificacion (mg)	Direcciones (ex: como tomar y cuantas veces al dia)

Si usted tiene un seguro de Medicare D, por favor de presentarlo a la recepcionista.