Citrus Valley Gastroenterology

LAST NAME_______________________ FIRST_______________________ MIDDLE_____

ADDRESS_______________________ CITY_________________ STATE____ ZIP_______

DATE OF BIRTH_________________ AGE___________ MALE_____ FEMALE ______

RACE_________________ LANGUAGE__________________ ETHNICITY___________

HOME_________________ CELL______________ E-MAIL________________________

APPOINTMENT REMINDER : TEXT _________ PHONE CALL____________

PATIENT EMPLOYED BY____

BUSINESS PHONE_______________ EXT #________ OCCUPATION_________________

REFERRING PRIMARY DOCTOR? _______________________ TEL#_________________

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? ____

RELATIONSHIP TO PATIENT_________________________ PHONE_________________

ANY RECENT BLOOD WORK? YES NO

ABDOMINAL ULTRASOUND? YES NO

ABDOMINAL CT SCAN? YES NO

ARE YOU OXYGEN DEPENDENT? YES NO

ARE YOU UNDER DIALYSIS TREATMENT? YES NO

YOU NEED TO BE INFORMED THAT IF THE PHYSICIAN PERFORMING YOUR PROCEDURE FINDS A POLYP OR ABNORMALITY, YOUR BENEFITS MAY CHANGE AND YOUR INSURANCE POLICY WILL PAY DIFFERENTLY.

Patient Signature_______________________________________ **Date**________________

Welcome to Citrus Valley Gastroenterology

Please fill out the information found below to the best of your ability.

Patient Name_____________________ **Date of Birth**___________ **Today's Date**__________

Evaluation at the request of Dr.____________________ **Appointment Reason**______________

Pharmacy Name:

Address______________________________ **Tel**______________

I ALLOW THE DOCTOR/NURSE TO LEAVE TEST RESULTS ON MY ANSWERING MACHINE/VOICE MAIL YES NO OR I PREFER TO PERSONALLY SPEAK WITH THE DOCTOR/NURSE ABOUT MY TEST RESULTS.

YOUR PAST MEDICAL HISTORY

Do you have history of High Blood Pressure, **or** ever been diagnosed? **Yes**_____ **or** No_____

History of Heart Attack ☐	Diabetes ☐	**HIV** ☐	Colon Polyps ☐	Emphysema ☐
Congestive Heart Failure ☐	Anemia ☐	Cirrhosis ☐	Kidney Disease ☐	History of Stroke ☐
History of Blood Clots ☐	Asthma ☐	GERD ☐	High Cholesterol ☐	Thyroid disease ☐
Cancer ☐ if yes, **what type** ____________			**Hepatits ☐ if yes, A ☐, B ☐ or C ☐**	Coronary Artery Disease ☐

YOUR PAST SURGERIES

Uterus/Ovaries Removal ☐	Pacemaker ☐	Breast ☐	Heart bypass ☐	Intestine ☐	Hernia ☐
Hip ☐ **or Knee Replacement** ☐	Heart/Stent ☐	Appendix ☐	Gallbladder ☐	C-Section ☐	Thyroid ☐
AICD (Defribulator) ☐	Gastric bypass ☐				

YOUR PREVIOUS PROCEDURES

Colonoscopy Yes☐ - No☐ if yes, when____________ **and where**______________

Endoscopy Yes☐ - No☐ if yes, when____________ **and where**______________

FAMILY HISTORY OF MEDICAL PROBLEMS

Do you have Family History of: **Adopted Yes ☐ No ☐**

Colon Cancer:	Yes ☐ No ☐	If yes, ☐**Father** ☐**Mother** ☐**Brother** ☐**Sister**
Stomach Cancer:	Yes ☐ No ☐	If yes, ☐**Father** ☐**Mother** ☐**Brother** ☐**Sister**
Liver Disease:	**Yes ☐ No ☐**	**If yes,** ☐Father ☐Mother ☐Brother ☐Sister

Do you smoke? Former☐ Current☐ or Never☐

Do You Drink Alcohol? Rarely☐ Occasional☐ Social☐ Daily☐ Former☐ or Never☐

Marital Status: Single ☐ / Divorced ☐ / Married ☐ / Widow/Widower ☐ / Occupation__________

Do you use street drugs?

Did You Bring Your Medications? If No, What Medications Do You Take:

Are You Allergic To Any Medications:

What Is The Reaction?______________

REVIEW OF SYMPTOMS

Do you have any of the following:

Difficulty Swallowing ☐	Constipation ☐	Abdominal Pain ☐	Acid Reflux ☐	Diarrhea ☐
Arthritis/Muscle Pain ☐	Rectal Bleeding ☐	Chest Pain ☐	Headaches ☐	

Citrus Valley Gastroenterology

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your *best possible health* requires a "partnership" between you and your doctor. As our "partner in health" we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings. I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (colonoscopies, mammograms, immunizations, pap smears etc). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition please ask.

Citrus Valley Gastroenterology
And Its Affiliated Physicians

Patient Signature/Guardian ______________________ Date ______________________ Physician Signature

Print Name: ______________________ DOB ______________________

Citrus Valley Gastroenterology

MEDICAL RECORDS RELEASE

Date:

All your medical information is confidential under state and federal laws. Your medical information cannot be released without signing a Medical Records Release form. Medical information is submitted with claims to evaluate medical necessity.

I ______________________________hereby authorize you to release to any individuals listed below and to my referring doctor any information including the diagnosis and record(s) of any treatment or examination rendered to me.

Send to Referring Doctor____

Authorization For listed individual is limited to the following records and type of information:

LIST NAME (S) OF AUTHORIZED INDIVIDUALS SUCH AS: Spouse, Children, Siblings, etc.

______________________	______________________	______________________
Name (PRINT)	Relationship	Date of Birth
______________________	______________________	______________________
Name 9PRINT)	Relationship	Date of Birth
______________________	______________________	______________________
Name (PRINT)	Relationship	Date of Birth

I understand that the requester may not further use or disclose the medical information unless authorization is obtained from the patient or unless such use or disclosure is specifically required or permitted by law.

Medical records release requested by the patient

To our patients: There may be a fee for the copying of records. The copy fee is based on the size of the chart and is payable at the time of request. Please allow three days for the retrieval and copying of records.

Medical records will be used for: [ ]Follow-up care [ ]Insurance [ ]Attorney Other______________________

______________________________ ______________________________

Patient Name (PRINT) Date of Birth

X______________________________ ______________________________

Patient Signature Date

Welcome to Our Practice

Citrus Valley Gastroenterology

500 W. San Bernardino Rd., Ste. B
Covina, CA 91722
T. 626-960-2326 F. 626-960-9796

415 W. Route 66, Ste. 102
Glendora, CA 91740
T. 626-610-2112 F. 626-610-2119

NOTICE

/

PATIENTS WITH AN HMO, PPO, EPO, MEDICARE AND/OR MEDICARE SUPPLEMENT INSURANCE

THE OFFICE WILL BILL YOUR INSURANCE FOR SERVICES RENDERED. IF YOUR INSURANCE DOES NOT PAY FOR THE SERVICE (S) DUE TO YOUR DEDUCTIBLE, LACK OF BENEFITS ACCESABILITY, OR TEMINATION OF BENEFITS, THEN YOU WILL BE FULLY RESPONSIBLE FOR ANY BALANCES.

____
PATIENT NAME (PRINTED)

____
DOB

____
PATIENT SIGNATURE (LEGAL GUARDIAN)

____
DATE

Citrus Valley Gastroenterology

PATIENT PAYMENT RESPONSIBILITIES

I understand that when services are rendered from Citrus Valley Gastroenterology, I am responsible for any deductible, copay, or other balance not covered by my insurance carrier. I authorize Citrus Valley Gastroenterology to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to Citrus Valley Gastroenterology. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to Citrus Valley Gastroenterology.

I understand that it is my responsibility to notify CVGastro if my Insurance, Address or Phone Number changes.

FOR PROCEDURES: I have been informed that I will possibly be receiving three (3) different statements from three separate entities (provider, facility, and pathology lab).

Patient Signature____ **Date**__________________

Primary Policy Holder Name________________________________ **Date**__________________

Secondary Policy Holder Name______________________________ **Date**__________________

Medication Refill Policy

1. Request for medication refills may take 48-72 hours for a response to the request.

Plan Ahead

2. You should contact CVG, your Gastro's office, three (3) days before your medication is due to run out. If you use a mail order company, please contact your provider fourteen (14) days before your medication is to run out. Messages should be left for the staff.

3. It may take 2-3 business days to refill your prescription. We must review your medical records, check for expiration dates, verify the number of refills and ensure eligibility. Once the necessary information has been researched, it is presented to the doctor for final authorization. Certain medications require laboratory testing before they can be refilled and you might need to see the doctors before we can authorize a refill.

4. Refill requests may also be made through your pharmacy. The pharmacy will forward the necessary information to our office to begin the process.

5. Refills on medication can only be authorized on medications prescribed by physicians in our office. We will not prescribe medications prescribed by other physicians.

6. Refills will be handled **ONLY** during our regular clinic hours, Monday thru Friday 9am to 5pm. We cannot fill medication after hours or on weekends.

Signature Date

Please print name DOB

CITRUS VALLEY GASTROENTEROLOGY

ESTABLISHED 1985

HIPAA POLICY/CONSENT

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that health information is protected for privacy. The Privacy Rule was also created to provide for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatments, payments or health care operations.

As our patient we want you to know that we respect the privacy of your personal records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to sign patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent, at some future time you may request to refuse all or part of your PHI.

You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please speak with out HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictors and revoke consent in writing after you have reviewed our privacy notice.

We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. Our policy is to listen to our patients and our employees. We welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

I have read and understand the above.

____
Signature

____
Date