

NORTH COUNTY GASTROENTEROLOGY MEDICAL GROUP, INC.

3923 Waring Road, Suite A • Oceanside, CA 92056

(760) 724-8782 • Fax (760) 724-2909

www.ncgastro.com

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Information Forms

Welcome to the office of North County Gastroenterology Medical Group, Inc. We are located near the Tri City Medical Center in Oceanside, CA. You may call us at the above number if you need detailed directions.

Our appointment times are very limited. With our backlog of patients needing appointments we believe it is not fair to other patients when an appointment time goes unused. **Because of the time allocated for new patients we need at least 2 business day's notice of cancellation or there will be a \$35.00 fee for the unused appointment.**

Your visit will include a physical examination by the physician. To make that examination easier, we recommend that you wear comfortable clothing.

Please read and complete the enclosed forms. It is very important that they be completed and brought with you to your appointment.

- 1.) A TWO PAGE MEDICAL HISTORY.
- 2.) A MEDICATION & ALLERGY LIST. (On the medication list please list the name of the drug, the strength, and how you are taking the drug. Please include any vitamins or dietary supplements that you are taking.)
- 3.) A PATIENT INFORMATION FORM.
- 4.) A PATIENT FINANCIAL RESPONSIBILITY FORM.
- 5.) AN ARBITRATION AGREEMENT (example).

Before making the trip to the office, please remember the following:

1. We need you to bring your completed forms above.
2. For scanning purposes, we need your actual insurance card. Bring any insurance co-payments. If you arrive without your card(s) or co-pay your appointment will have to be rescheduled.
3. Please arrive at the office 15 minutes prior to your scheduled appointment to complete the check-in process.

INSURANCE INFORMATION: We will file claims with your primary and secondary insurance carriers if you provide all necessary information (i.e. current insurance cards and correct billing address).

Co-pays are collected for each visit at check-in. Share of cost will be collected from all others at time of check-out. We accept cash, checks, or credit cards.

Please be advised that we do have a \$25.00 fee for all returned checks.

FINANCIAL RESPONSIBILITY: Please refer to the "Patient Financial Responsibility Form". See #1. Financial Responsibility.

PATIENT INFORMATION FORM
WELCOME TO NORTH COUNTY GASTROENTEROLOGY

Please print in Black Ink

DATE: _____

PATIENT NAME: _____ Pt # _____

MALE _____ FEMALE _____ AGE _____ DATE OF BIRTH _____ MARITAL STATUS: S M W D

ADDRESS: _____ APT #: _____ CITY: _____ STATE _____ Zip _____

HOME PHONE: () _____ CELL: () _____ E-MAIL _____

EMPLOYER: _____ ADDRESS: _____

OCCUPATION: _____ WORK PHONE: () _____

SS #: _____ DRIVER'S LICENSE #: _____ STATE: _____

SPOUSE OR RESPONSIBLE PARTY: _____ DOB: _____

SS #: _____ EMPLOYER: _____

WORK PHONE: () _____ HOME PHONE (if different): _____

PERSON TO NOTIFY IN EMERGENCY: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: () _____

WHO IS YOUR PRIMARY CARE DOCTOR?: _____

WHO REFERRED YOU TO OUR OFFICE?: _____

Will you be using your POS option? _____

INSURANCE INFORMATION

AS A COURTESY we will bill your primary and secondary insurance carrier if you provide **ALL** necessary information (such as insurance cards and/or completed and signed claim forms if your carrier requires it and their **CORRECT** billing address). **HMO co-pays are collected for each visit at check in.** Share of cost will be collected from all others at the time of check out. **A \$25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.**

PRIMARY INSURANCE

Insurance Name: _____

Claims Address: _____

Employer Group Plan: _____ Individual Plan: _____

Policyholder Name: _____

SELF ~ SPOUSE ~ PARENT

Policyholder DOB: _____

Policyholder ID: _____

Group #: _____

SECONDARY INSURANCE

Insurance Name: _____

Claims Address: _____

Employer Group Plan: _____ Individual Plan: _____

Policyholder Name: _____

SELF ~ SPOUSE ~ PARENT

Policyholder DOB: _____

Policyholder ID: _____

Group #: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: X _____

For billing purposes we require this form to be fully completed. We reserve the right to reschedule any appointments due to incomplete forms or tardiness.

Please let us know within 48 hours if you are unable to keep your appointment. A fee of \$35.00 will be charged for that unused appointment time if we are not notified.

WE APPRECIATE YOUR COOPERATION.

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ **Date:** _____

The physicians of North County Gastroenterology Medical Group, Inc. require this form to be signed by their patients. We appreciate your cooperation.

If you have ANY questions, please ask the receptionist.

FINANCIAL RESPONSIBILITY (3 Scenarios)

1. If I have no insurance I understand that I will be personally responsible for any medical fees I will incur with North County Gastroenterology Medical Group, Inc.
OR
2. If I have an HMO or coverage by a State or Federally funded program with which North County Gastroenterology Medical Group, Inc. is contracted I agree that I will be responsible for any charges incurred if I do NOT provide my most current and correct insurance to the office at the time of my services. I understand that I will need a current authorization for my services from my HMO.
OR
3. If I have insurance I understand I will be personally responsible for any deductibles or co-pays that my insurance coverage determines. I agree to furnish up to date insurance information and a current insurance card whenever having services in the office.

I have read and agree to the terms above that apply to me.

Signature of Patient or Legal Guardian:X _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize North County Gastroenterology to release medical information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care.

Signature of Patient or Legal Guardian:X _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment for medical services provided directly to the North County Gastroenterology Medical Group physicians.

Signature of Patient or Legal Guardian:X _____

It is our policy to leave medical information, such as normal blood test results, normal biopsy reports on your answering machine or with someone residing at your home. By signing below I agree with this policy, otherwise speak with the receptionist.

Signature of Patient or Legal Guardian:X _____

To be signed at check in:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY: I acknowledge that I have received a copy of North County Gastroenterology Medical Group's Privacy Policy.

Date: _____ **Signature of Patient or Legal Guardian:X** _____

**NORTH COUNTY GASTROENTEROLOGY MEDICAL GROUP, INC.
TRI-CITY GASTROENTEROLOGY MEDICAL GROUP, INC.**

3923 WARING ROAD, SUITE A, OCEANSIDE, CALIFORNIA 92056 - 4497
PHONE (760) 724 - 8782 www.ncgastro.com FAX (760) 724 - 2909

NAME _____ PRIMARY DOCTOR: _____

DATE OF BIRTH _____ AGE _____ REFERRING DOCTOR: _____

CHIEF COMPLAINT:

PHYSICIAN'S COMMENTS (HPI):

Do you have a pacemaker or a defibrillator? (If yes, we need to copy your card) ___yes ___no
Are you taking any blood thinners? Aspirin, Plavix, Coumadin, etc ___yes ___no

Have you ever seen a stomach, colon, or liver specialist: (Gastroenterologist)? ___yes ___no
If yes, name of Doctor: _____

Have you ever had any of the following tests?	YES	NO
Colonoscopy or Sigmoidoscopy		
Upper endoscopy (EGD)		
Stomach xray (upper GI)		
Colon xray (Barium Enema)		
Gallbladder ultrasound		
CT scan of your abdomen		

Have you ever had any of the following medical problems?	YES	NO
Colon polyps		
Colon cancer		
Colitis		
Diverticulitis		
Ulcers		
Hepatitis, Liver problems		
Gallstones		
Pancreatitis		

Are you currently experiencing any of the following problems?	YES	NO
Abdominal pain		
Heartburn		
Bloating		
Nausea		
Vomiting		
Trouble swallowing, Food getting stuck		
Change in bowel habits		
Constipation: hard stools		
Constipation: infrequent stools		
Diarrhea		
Black stools		
Rectal bleeding		
Yellowness of skin or eyes (Jaundice)		
Weight loss (unintentional)		
Milk causes gas		
Milk causes diarrhea		
Wheat causes digestive problems		

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Authorized Representative's Signature Date

By: _____
Patient's or Patient Representative's Signature Date

By: _____
Print Patient's Name

Print or Stamp Name of Physician,
Medical Group, or Association Name

(If Representative, Print Name and Relationship to Patient)