ENDOSCOPY CENTER OF WESTERN COLORADO

PLEASE RETURN PAPER TO OUR OFFICE, NOT THE HOSPITAL. THANKS

NAME: _____ DATE OF BIRTH: _____
SS#: _____ GENDER: _____ OCCUPATION: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE: _____ CELL: _____ WORK: _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ ADDRESS: _____
EMERGENCY CONTACT: _____ PHONE: _____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____
CAN WE LEAVE A MESSAGE ON YOUR CONTACT PHONE? YES/ NO

PLEASE CIRCLE THOSE THAT APPLY

RACE: AMERICAN INDIAN/ALASKA NATIVE — NATIVE HAWAIIAN/PACIFIC ISLANDER
ASIAN — WHITE
BLACK/AFRICAN AMERICAN — OTHER: _____

ETHNICITY: HISPANIC/LATINO — NOT HISPANIC/LATINO
LANGUAGE: _____

SPOUSE/PARENT (MUST BE FILLED OUT IF PATIENT IS A MINOR) INFORMATION

NAME: _____ DATE OF BIRTH: _____
SS#: _____ GENDER: _____ OCCUPATION: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ CELL: _____ WORK: _____

MUST HAVE INSURANCE CARD(S) AND VALID ID PRESENT AT YOUR APPOINTMENT

REVISED 6/10/15 DH/PMQ

If you need to cancel or reschedule your appointment, it must be done 24 hours (or more) in advance. If you do not notify the office 24 hours (or more) before your scheduled appointment, you will be charged a no-show fee of $30 (for the office visit) or $200 (for the procedure.)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE DR. MASI KHAJA TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I AM AWARE THAT I AM RESPONSIBLE FOR THE TOTAL FEE CHARGES AND WILL BE HELD RESPONSIBLE FOR THE COLLECTIONS FEES, ATTORNEY AND COURT COSTS INCURRED IN COLLECTING ANY DELINQUENT ACCOUNT BALANCES. IF THE ACCOUNT IS TURNED OVER FOR COLLECTION AN ADDITIONAL COLLECTION CHARGE WILL BE ASSESSED.

PROFESSIONAL FEES

IF YOU HAVE A PROCEDURE DONE BY DR. MASI KHAJA, YOUR INSURANCE COMPANY WILL BE BILLED FOR ALL PROCEDURES. THERE MAY BE ADDITIONAL COST INVOLVED DUE TO WHAT THE DOCTOR FINDS. THIS CANNOT BE DETERMINED PRIOR TO YOUR PROCEDURE. ALL OFFICE VISITS PRIOR TO OR AFTER YOUR PROCEDURE WILL BE BILLED SEPERATELY AND YOU WILL BE RESPONSIBLE FOR APPLICABLE COPAYS AND DEDUCTIBLES.

A WORD ABOUT PAYMENTS

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF THE INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH THE OFFICE MANAGER.

PRIVACY PROCEDURES PER HIPAA

I HAVE BEEN OFFERED OR HAVE RECEIVED A COPY OF DR. KHAJA'S POLICY AND PROCEDURE FOR NOTICE OF PRIVACY PRACTICES.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

****** MASI KHAJA, M.D. DS THE SOLE OWNER AND OPERATOR OF
THE ENDOSCOPY CENTER OF WESTERN COLORADO******

PATIENT PERSONAL HISTORY

PATIENT NAME: _____ DOB: _____

HAVE YOU EVER HAD A COLONOSCOPY/ENDOSCOPY? YES/ NO IF SO, WHEN? _____

WHO PERFORMED THE PROCEDURE? _____

PHARMACY: _____ PHONE: _____

REASON FOR VISIT: _____

DRUG ALLERGIES/REACTION: _____

_____

CURRENT MEDICATIONS (Including Herbs/ Supplements)

MEDICATION	DOSAGE	REASON

SURGERIES: YES/ NO (IF YES, PLEASE LIST)

_____

IS THERE ANY FAMILY HISTORY OF COLON CANCER, POLYPS, GI PROBLEMS, OR OTHER CANCER?

_____

ANY COMPLICATIONS WITH SEDATION? YES/ NO

IF YES, EXPLAIN: _____

HABITS

DO YOU SMOKE OR CHEW TOBACCO? YES/ NO

IF YES, HOW MUCH AND FOR HOW LONG? _____/_____

DO YOU DRINK ALCOHOL? YES/ NO

IF YES, HOW MUCH AND FOR HOW LONG? _____/_____

HAVE YOU EVER DONE ILLICIT DRUGS? YES/ NO

IF YES, WHAT? _____ HAVE YOU QUIT? YES/ NO

MEDICAL HISTORY

DIABETIC: (TYPE)				YES	NO
CANCER: (TYPE)				YES	NO
HEART DISEASE/ ATTACK: (EXPLAIN)				YES	NO
IRREGULAR HEART RATE:				YES	NO
RECENT VACCINATION:				YES	NO
OTHER:				YES	NO
ABNOMAL: KIDNEYS, LIVER, THYROID	YES	NO	HEPATITIS: A, B, OR C	YES	NO
ACID REFLUX	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTHRITIS: RHEUMATOID, OSTEO	YES	NO	HIGH CHOLESTEROL	YES	NO
ASTHMA/BRONCHITIS	YES	NO	IBS	YES	NO
BARRETT'S ESOPHAGUS	YES	NO	SLEEP APNEA	YES	NO
BLEEDING DISORDER	YES	NO	STROKE	YES	NO
CHRONIC PAIN/ FIBROMYALGIA	YES	NO	TIA	YES	NO
COPD	YES	NO	TUBERCULOSIS	YES	NO
CROHN'S	YES	NO	ULCERATIVE COLITIS	YES	NO
DEPRESSION	YES	NO			

DO YOU HAVE ANY OF THE FOLLOWING:

BLACK TARRY STOOL	YES	NO	POOR APPETITE	YES	NO
BLOOD IN STOOL	YES	NO	UNEXPLAINED WEIGHT LOSS	YES	NO
CONSTIPATION	YES	NO	VOMITING BLOOD	YES	NO
DIARRHEA	YES	NO	DENTURES/PARTIALS	YES	NO
DIFFICULTY SWALLOWING	YES	NO	GLASSES/CONTACTS	YES	NO
INDIGESTION/HEARTBURN	YES	NO	HEARING AID	YES	NO
NAUSEA/VOMITING	YES	NO	POSSIBILITY OF PREGNANCY?	YES	NO

TO THE BEST OF MY KNOWLEDGE ALL MEDICAL INFORMATION PROVIDED IS CORRECT.

SIGNATURE: _____ DATE: _____

ENDOSCOPY CENTER OF WESTERN COLORADO

YOUR RIGHTS AS A PATIENT

- The right to impartial access to treatment, regardless of race, religion, gender, sexual orientation, ethnicity, age or disability.
- The right for the patient, or his/her representative, to be fully informed in advance, and to make informed decisions about care or treatment and to actively participate in the planning of his/her care.
- To receive appropriate privacy, confidentiality and security concerning you and your medical care. Every effort will be made to maintain your privacy during all phases of your stay.
- The right for the patient to receive care in a safe environment and to be actively involved in the safety strategy.
- The right to be free of all forms of abuse or harassment, restraint or seclusion
- The right to know that all advanced directives and CPR directives are suspended during the procedure.
- The right to refuse treatment and to be informed of the consequences of your actions.
- To know if any research will be done during treatment and the right to refuse.
- The right to be given the opportunity to participate in decisions involving your care, treatment and services, including pain management, except when such participation is contraindicated for medical reasons.
- To be informed of any persons other than routine personnel who will be observing or participating in your treatment.
- The right to know the professional status of all persons providing your care. All staff will introduce themselves to patients and family and states their status, i.e. RN, Endotech, MA.
- The right to access information contained in his/her medical records. Upon *written* request, a copy of the patient's medical record can be provided for a fee.
- The right to confidentiality of his/her medical records maintained by the facility. Access to the medical records shall be limited to the patient, individuals directly involved with the patient care, individuals monitoring the quality of patient care and those individuals authorized by law or regulatory agency.
- To know the methods for expressing privacy concerns, grievances and suggestions to facility including external appeals as required by state and federal regulations.
- Upon request to know, in advance, the estimated amount of your bill.
- Upon request, to examine and receive an explanation of the final bill, regardless of the source of payment.
- To have the right to be informed of the mechanism by which you will have continuing health care following discharge from the facility. (discharge instructions)
- The rights to be informed of the need for his/her transfer to an outside facility for a higher level of care that is not provided at this facility.

DATE: _____ TIME: _____

PATIENT NAME: _____

RELEASE OF HEALTH RECORDS TO:

Gastroenterology Associates & Endoscopy Center of Western Colorado
2460 Patterson Road, Suite 4
Grand Junction, CO 81505
Phone: 970-245-0990
Fax: 970-245-2335

PATIENT NAME: _____ DOB:_____

RELEASING OFFICE: _____

PHONE:_____FAX: _____

TRANSFER OF CARE

OR (circle one)

SECOND OPINION

BY SIGNING THIS FORM YOU ARE GIVING OUR OFFICE PERMISSION TO REQUEST AND ACCESS ALL YOUR RECORDS NEEDED TO CONTINUE YOUR CARE. YOU MAY CHOOSE TO EXCLUDE ANY OF THE FOLLOWING:

- ☐ DRUG ABUSE
- ☐ ALCOHOL ABUSE
- ☐ HIV/ AIDS INFORMATION
- ☐ PSYCHOLOGICAL CONDITION
- ☐ OTHER

PATIENT SIGNATURE: _____ DATE: _____

EXPIRES: ONE YEAR FROM DATE SIGNED