Jyotsna Ravi, MD | Jagdish Patel, MD | Malvinderjit Singh, MD

13128 N. 94th Drive Suite 201, Peoria, Arizona 85381
Phone: 623-209-7227 | Fax: 623-209-7302

DHC Assignment of Benefits and HIPAA

Patient Name: **DOB (age):**

Account #:

The Department of Health and Human Services began enforcing regulations designed by the Health Insurance Portability and Accountability Act on April 14th, 2003 in keeping with the regulations imposed by this act, our practice will provide services when the patient agrees to:

- Sign consent allowing us to use your protected health information to collect payment for services, or
- Upon receipt of cash for the services on the day of the visit.

I agree to permit my protected health information to be used and disclosed for purposes of treatment, payment, and health care operations.

For details about these uses and disclosures, please see our Privacy Notice. We reserve the right, as your healthcare provider, to change our privacy policies described in the Privacy Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment and payment of health care operations. We are not required to agree with this request, but should we agree to, we are bound by the agreement.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have already acted in reliance upon the use or disclosure of your information.

INSURANCE: For patient's convenience, we file medical claims with the insurance plans with which we have an agreement, if valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of his or her insurance claim. The patient will be considered self-pay until this information is provided to us. The patient is responsible for notifying our office of any insurance changes prior to scheduled appointments.

Co-payments and deductibles. All co-payments and previous balances must be paid at the time of service. This arrangement is part of your contract with your insurance company.

SELF PAY: For self pay patients or patients who loose their insurance the following rates apply. New patients or patients who have not been seen in 3 years are more will have a $100 payments. For all established patients follow up appointments are $40.

RELEASE OF INFORMATION: I hereby authorize Digestive Health Clinic to release information to my insurance company about all treatment as necessary to obtain payment for services and to review activity related to the provider's participation with my insurance plan. I consent to the assignment of my benefits directly to the physician and understand that I may be responsible for non-covered charges as allowed by my insurance carrier.

I hereby grant permission to the below listed person(s) to receive medical information on my behalf, pick up prescriptions on my behalf, verify appointments on my behalf and receive copies of medical records on my behalf:

Name	*Relationship*	*Phone*	*Emergency Contact?*

I authorize permission to leave detailed messages on my voicemail

This form will remain in effect until I revoke permission with a written notification.

Reviewed with:
Relationship to Patient:

_____
Signature

Jyotsna Ravi, MD | Jagdish Patel, MD | Malvinderjit Singh, MD

13128 N. 94th Drive Suite 201, Peoria, Arizona 85381
Phone: 623-209-7227 | Fax: 623-209-7302

DHC Assignment of Benefits and HIPAA

Patient Name: **DOB (age):**

Account #:

The Department of Health and Human Services began enforcing regulations designed by the Health Insurance Portability and Accountability Act on April 14th, 2003 in keeping with the regulations imposed by this act, our practice will provide services when the patient agrees to:

- Sign consent allowing us to use your protected health information to collect payment for services, or
- Upon receipt of cash for the services on the day of the visit.

I agree to permit my protected health information to be used and disclosed for purposes of treatment, payment, and health care operations.

For details about these uses and disclosures, please see our Privacy Notice. We reserve the right, as your healthcare provider, to change our privacy policies described in the Privacy Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment and payment of health care operations. We are not required to agree with this request, but should we agree to, we are bound by the agreement.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have already acted in reliance upon the use or disclosure of your information.

INSURANCE: For patient's convenience, we file medical claims with the insurance plans with which we have an agreement, if valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of his or her insurance claim. The patient will be considered self-pay until this information is provided to us. The patient is responsible for notifying our office of any insurance changes prior to scheduled appointments.

Co-payments and deductibles. All co-payments and previous balances must be paid at the time of service. This arrangement is part of your contract with your insurance company.

SELF PAY: For self pay patients or patients who loose their insurance the following rates apply. New patients or patients who have not been seen in 3 years are more will have a $100 payments. For all established patients follow up appointments are $40.

RELEASE OF INFORMATION: I hereby authorize Digestive Health Clinic to release information to my insurance company about all treatment as necessary to obtain payment for services and to review activity related to the provider's participation with my insurance plan. I consent to the assignment of my benefits directly to the physician and understand that I may be responsible for non-covered charges as allowed by my insurance carrier.

I hereby grant permission to the below listed person(s) to receive medical information on my behalf, pick up prescriptions on my behalf, verify appointments on my behalf and receive copies of medical records on my behalf:

Name	*Relationship*	*Phone*	*Emergency Contact?*

I authorize permission to leave detailed messages on my voicemail

This form will remain in effect until I revoke permission with a written notification.

Reviewed with:
Relationship to Patient:

_____
Signature

Jyotsna Ravi, MD | Jagdish Patel, MD | Malvinderjit Singh, MD

13128 N. 94th Drive Suite 201, Peoria, Arizona 85381
Phone: 623-209-7227 | Fax: 623-209-7302

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

Email
Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race
Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ Arabic ☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Home phone ☐ Cell phone ☐ Email ☐ Patient declines to specify Other:_____

Pharmacy

Name Address Phone

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Latex gloves ☐ Penicillins ☐ Sulfa ☐ Propofol ☐ Iodine/IV Dye

☐ Eggs Other:_____

Past or Present Medical Conditions

- [ ] None

Neurology:	Stroke/TIAs	Seizure disorder	Dementia	Parkinson's Disease
Endocrine:	Hypothyroidism	Diabetes	Osteoporosis	Elevated Cholesterol
Cardiac:	High Blood Pressure	Heart Attack	Atrial Fibrillation	Congestive Heart Failure
Pulmonology	COPD	Bronchial Asthma	Sleep apnea	Valley Fever
	On home oxygen therapy			
Gastrointestinal:	Barrett's Esophagus	History of Colon Polyps	Diverticulitis	Pancreatitis
	GERD	Colon cancer	IBS	Cirrhosis of Liver
	Peptic Ulcer Disease (PUD)	Ulcerative Colitis	Lactose Intolerance	Hepatitis B
	H. Pylori	Crohn's Disease	Celiac Disease	Hepatitis C
	Fatty Liver			
Urinary:	Chronic renal failure	Enlarged Prostate	Prostate Cancer	Kidney Stones
Rheumatology:	Fibromyalgia	Lupus	Rheumatoid arthritis (RA)	
Blood:	Anemia	Leukemia	Lymphoma	Bleeding disorder
Psychiatric:	Anxiety	Depression	Bipolar disorder	Schizophrenia
Circulation:	Deep vein thrombosis (DVT)	Pulmonary embolism (PE)	Peripheral vascular disease	Carotid artery disease
Other:	Breast cancer	Lung cancer	Ovarian Cancer	Other:
	Tattoos	HIV infection		

Diagnostic Studies/Tests

- [ ] None

Colonoscopy	Upper Endoscopy	ERCP	EUS	Ultrasound
When:	When:	When:	When:	When:
CT Abdomen	MRI Abdomen	Liver Biopsy	DEXA Scan	Blood tests
When:	When:	When:	When:	When:

Previous Procedures

- [ ] None

Cataract Surgery	Gallbladder removed	Appendectomy	Colon resection	Small Bowel Resection
Gastric Bypass	Gastric Lap Band	Hemorrhoidectomy	Pacemaker	Defibrillator
Coronary Artery Bypass Graft (CABG)	Heart valve replacement	Cardiac Cath - with stent placement	Abdominal aortic aneurysm (AAA) repair	Joint Replacement
Tubal Ligation	Hysterectomy - Abdominal	C-Section	Lumpectomy	Mastectomy
Prostate surgery	Other:	Other:		

Social History

Occupation:_____ Number of Children:_____

Marital Status

- ⬭ Single
- ⬭ Married
- ⬭ Divorced
- ⬭ Separated
- ⬭ Widowed
- ⬭ Civil Union
- ⬭ Unknown
- ⬭ Other

Alcohol

- ⬭ None
- ⬭ Occasionally
- ⬭ Daily

Caffeine

- ⬭ None
- ⬭ Occasionally
- ⬭ Daily

Tobacco

Smoking Status

- ⬭ Current every day smoker
- ⬭ Current some day smoker
- ⬭ Former smoker
- ⬭ Never smoker
- ⬭ Smoker, current status unknown
- ⬭ Light tobacco smoker
- ⬭ Heavy tobacco smoker
- ⬭ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
⬭ Cigarettes				
⬭ Cigar				
⬭ Chewing Tobacco				

Drug Use

- ⬭ None

Type	Quantity	Number	Frequency
⬭ IV or intranasal drugs			Times / month
⬭ Recreational			Times / month

Immunizations

- ⬭ None
- ⬭ Flu vaccine When:_____
- ⬭ Hep A When:_____
- ⬭ Hep B When:_____
- ⬭ Pneumovax When:_____
- ⬭ TB skin test When:_____
- ⬭ Covid-19 When:_____
- Other:_____

Current Medications

- ⬭ None

Name	Dose	How taken?

Family Medical History

☐ No knowledge of family history

No family history of

☐ Celiac sprue
☐ Colon polyps
☐ Liver disease
☐ Ulcerative Colitis / IBD
☐ Colon cancer
☐ Crohn's disease
☐ Stomach cancer

	Mother	Father	Sister	Brother	Grandmother	Grandfather	Daughter	Son
Diagnoses								
Celiac Disease	○	○	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○

Review Of Systems

Cardiovascular

	Y	N
None		
chest pain		
palpitations		
peripheral edema		

Constitutional

	Y	N
None		
fatigue		
fever		
loss of appetite		
weight loss		

ENMT

	Y	N
None		
ear pain		
nasal obstruction		
nose bleeds		
hearing loss		

Endocrine

	Y	N
None		
excessive thirst		
heat intolerance		

Gastrointestinal

	Y	N
None		
abdominal pain		
abdominal swelling		
change in bowel habits		
constipation		
diarrhea		
gas		
heartburn		
nausea		
rectal bleeding		
stomach cramps		
vomiting		
difficulty swallowing		

Genitourinary

	Y	N
None		
dark urine		
dysuria		
frequent urination		
hematuria		

Hematologic/Lymphatic

	Y	N
None		
easy bruising		
prolonged bleeding		

Integumentary

	Y	N
None		
itching		
jaundice		
rashes		

Neurological

	Y	N
None		
dizziness		
fainting		
frequent headaches		
memory loss		

Psychiatric

	Y	N
None		
anxiety		
depression		

Respiratory

	Y	N
None		
cough		
dyspnea		
excessive sputum		
coughing up blood		
wheezing		

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

Yes No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Date