❑ Dr. Joe M. Chen
❑ Dr. Thai-Van Nguyen
❑ Dr. Timnit F. Tekeste
❑ Alfred T. Reyno, PA-C

PATIENT INFORMATION FORM

SoCal Gastroenterology

FULL NAME _____ **DATE OF BIRTH** _____ **SEX:** □ **M** □ **F**

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE #(_____)_____ EMAIL _____
CELL HOME WORK

OCCUPATION _____

SOCIAL SECURITY # _____ DRIVERS LICENSE #_____

MARITAL STATUS: □ SINGLE □ MARRIED □ OTHER SPOUSE'S NAME _____

RACE _____ ETHNICITY _____ PREFERRED LANGUAGE _____

SUBSCRIBER'S NAME (If different from above) _____

DATE OF BIRTH _____ SOCIAL SECURITY #_____

SUBSCRIBER'S EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PHONE # (_____)_____ EXT _____ HOW LONG EMPLOYED?_____

PRIMARY INSURANCE

NAME OF INSURANCE PLAN _____ DOB _____ ID# _____

NAME OF SUBSCRIBER _____ ID# _____

SECONDARY INSURANCE

NAME OF INSURANCE PLAN _____ DOB _____ ID# _____

NAME OF SUBSCRIBER _____ ID# _____

IN AN EMERGENCY, CONTACT _____ PHONE# _____
CELL HOME WORK

WHO REFERRED YOU TO OUR DOCTOR? _____

YOUR PRIMARY CARE PHYSICIAN IS _____ PHONE #_____
CELL HOME WORK

REASON FOR TODAY'S VISIT _____

I HEREBY ASSIGN THE BENEFITS DUE ME THROUGH MY INSURANCE CARRIER TO SOCAL GASTROENTEROLOGY FOR SERVICES RENDERED. I ALSO AUTHORIZE AND INSTRUCT MY INSURANCE CARRIER TO MAKE PAYMENTS OF AUTHORIZED BENEFITS TO SOCAL GASTROENTEROLOGY.

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY THE INSURANCE COMPANY, I AUTHORIZE RELEASE OF ALL MEDICAL INFORMATION REQUIRED TO PROCESS THIS CLAIM.

X _____ _____

SIGNATURE OF PARENT OR RESPONSIBLE PARTY **DATE**

❑ Dr. Joe M. Chen
❑ Dr. Thai-Van Nguyen
❑ Dr. Timnit F. Tekeste
❑ Alfred T. Reyno, PA-C

Acknowledgement of Notice of Privacy Practices

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for (SoCal Gastroenterology). Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. You may request a copy of the Notice of Privacy.

_____ _____
Signature of Patient /Patient Representative Date

_____ _____
Name of Patient/ Patient Representative (please print) Relationship to Patient

Authorization for Use and Disclosure of Medical Records

Patient Name:

_____
Last First MI Other Name

Date of Birth: ____-_____-_____ Phone: _____

Address: _____City:_____ST:_____Zip:_____

I authorize disclose of my protected health information to the following:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

This authorization shall remain in effect until it is revoked by a request in writing.

You have the right to receive a copy of this authorization.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

SoCal Gastroenterology

Patient Name: _____ DOB: _____ Today's Date: _____

Pharmacy Name/Address/Phone#: _____

Reason for your visit today:

_____
_____
_____
_____
_____
_____

Medications: *incl. Over-The-Counter meds* (Name / Dosage / Frequency)

_____
_____
_____
_____
_____
_____
_____
_____

Allergies: (include reactions)

_____
_____
_____

Height _____ Weight_____

Check box if you have ever had:

GI Past Medical History

- ☐ Barrett's Esophagus
- ☐ GERD / Reflux
- ☐ Helicobacter Pylori
- ☐ Hiatal Hernia
- ☐ Non-Ulcer Dyspepsia
- ☐ Peptic Ulcer Disease
- ☐ GI Bleed
- ☐ Colon Cancer (year _____)
- ☐ Colon Polyps (year _____)
- ☐ Diverticuliosis
- ☐ Diverticulitis of Colon
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Gallbladder Disease
- ☐ Pancreatitis
- ☐ Chronic Liver Disease
- ☐ Elevated Liver Enzymes
- ☐ Hepatitis

General Past Medical History

- ☐ Angina Pectoris
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Angioplasty
- ☐ Coronary Artery Stent
- ☐ Mitral Valve Prolapse
- ☐ Hypertension
- ☐ Hypertipidemia
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Peripheral Vascular Disease
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Glaucoma
- ☐ Anemia
- ☐ Diabetes Mellitis
- ☐ Hypothyroidism
- ☐ Chronic Renal Insufficiency
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Low Back pain
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Obesity
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Cancer
- ☐ Breast Cancer
- ☐ Prostate Cancer

- ☐ Last Colonoscopy _____
- ☐ Other _____

GI Surgery History

- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Biliary Tract Surgery
- ☐ Colectomy - Total Laparoscopic
- ☐ Colectomy - Partial Laparoscopic
- ☐ Colectomy - Partial
- ☐ Colectomy - Total Abdominal
- ☐ Gastric Surgery
- ☐ Gastric Bypass
- ☐ Ulcer Surgery
- ☐ hemorrhoidectomy
- ☐ Hernia Repair
- ☐ Inguinal Hernia Repair
- ☐ Nissen Fundoplication
- ☐ Small Bowel Resection

OB/GYN Surgery History

- ☐ Cesarean Section
- ☐ Tubal Ligation
- ☐ Vaginal Hysterectomy
- ☐ Partial Hysterectomy
- ☐ Total Hysterectomy and Ovary Removal
- ☐ Dilation and Curettage
- ☐ Bladder Suspension

General Surgery History

- ☐ Cataract Surgery
- ☐ Coronary Artery Bypass Graft (CABG)
- ☐ Tonsillectomy
- ☐ TURP
- ☐ Carotid Thromboendarterectomy

Orthopedic Surgery History

- ☐ Carpel Tunnel Repair
- ☐ Hip Surgery
- ☐ Knee Surgery
- ☐ Shoulder Surgery

☐ Other: _____
_____
_____
_____
_____
_____

Family History

- ☐ Colon Cancer
- ☐ Family history of colon polyps
- ☐ Cancer
- ☐ Other: _____
- ☐ Inflammatory Bowel Disease
- ☐ Early Deaths

Social History

- ☐ Alcohol Use
- ☐ Smoking
- ☐ Caffeine Use
- ☐ Drug Use

Marital History: S / M / D / W

Occupation: _____

_____ _____

SIGNATURE OF PARENT OR RESPONSIBLE PARTY **DATE**

SoCal Gastroenterology

FINANCIAL POLICY

Thank you for allowing us to participate in your health care. We are committed to your treatment being successful and as pleasant as possible. The following is our Financial Policy:

In the day and age of health plans, private insurance, medicare and medical insurance, we understand the medical insurance field can be quite confusing. We have attempted to clarify our responsibility to you, our patient, and your responsibility to your carrier.

1. **MEDICARE PATIENTS:** We are providers with Medicare and accept assignment on all claims. You are responsible for all deductibles. We will notify you when we are notified by Medicare what your deductible portion is. If you have supplemental insurance, we are happy to bill it out for you as a courtesy to you. We do this automatically unless you specifically instruct us to do otherwise. If you only have Medicare, your co-pay is due upon completion of service. The 20% co-pay is required by the medicare contract to be collected. Failure to do so puts your physician in jeopardy with Medicare.

2. **MEDI-CAL PATIENTS:** You are responsible for your Medi-Cal card. If you do not have your card, your appointment will be rescheduled!

3. **PRIVATE INSURANCE:** You may be responsible for a percentage of physician's fees as well as your deductible. You may also need authorization to be seen. You should familiarize yourself with the amount of your yearly deductible. Check your insurance book for physician participation. When in question, call your company. You will receive monthly statements showing any insurance payments we have received. We pride ourselves in getting your claim mailed within a few days of your service. You will also receive a patient balance notice after your insurance has paid in full.

4. **HMO PLANS:** Because our doctor's are specialists, you have been referred by your primary care physician. You are responsible for making sure that we have a valid authorization to see you. You should familiarize yourself with your co-pay amount which can usually be found on your health plan card. If it is not listed, call your plan and write on your card for reference. Your co-pay is due before seeing the physician.

5. **NO INSURANCE:** Payment in full is due at the time of service.

6. **METHODS OF PAYMENT:** We accept cash, check or an approved payment plan worked out with our Billing Department.

7. **APPOINTMENTS:** We are happy to reschedule your appointment. Please be aware that a fee will be applied to your account for failed or cancelled appointments without a prior notification of 48 hours Monday - Friday, 9:00 am - 4:30 pm.

8. **OPEN ACCOUNTS:** We will do everything possible to make it easy for you to take care of your financial responsibility. We would appreciate a phone call in the event that you are experiencing problems.

9. **ASSIGNMENT OF BENEFITS:** You will be asked to sign an assignment of benefits for Medicare as well as all insurance plans. If you receive payment, please remit in full to our office so that your account can be credited properly. Remember: This money you receive is not yours! It belongs to the physcians for the services provided to you.

10. **BILLING QUESTIONS:** Please contact our Billing Department at 562-493-1011 ext. 3954 between 7:00 am - 3:30 pm, Monday - Friday.

Thank you for trusting us with your care and if you have any questions, please do not hesitate to contact this office. Our staff is always here to listen and help!

I have read and understood the above information. I am in full agreement with this financial policy.

Signature X_____ Date_____

SoCal Gastroenterology

JOE M. CHEN, M.D., F.A.C.G.
THAI-VAN X. NGUYEN, M.D.
TIMNIT F. TEKESTE, M.D., M.P.H.
ALFRED T. REYNO, PA-C

10931 CHERRY STREET, SUITE 300
LOS ALAMITOS, CALIFORNIA 90720
(562) 493-1011 • FAX (562) 594-9226

1. CONSENT TO TREATMENT. The undersigned consents to health care encompassing routine diagnostic procedures, medical treatment, and other health services rendered to the patient by SoCal Gastroenterology.

2. NO GUARANTEES. It is understood that the practice of medicine and surgery and the rendering of health care is not an exact science and that no guarantees have been made as to the results of treatments, examinations or other health services rendered by SoCal Gastroenterology.

3. RELEASE OF INFORMATION. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, SoCal Gastroenterology, may disclose portions of the patient's records, including his/her medical records, to any person or entity which is or may be liable, for all or any portion of SoCal Gastroenterology charges. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.

4. ASSIGNMENT OF INSURANCE BENEFITS. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to SoCal Gastroenterology of any insurance benefits otherwise payable to or on behalf of the undersigned for treatment and health care services rendered by SoCal Gastroenterology, at a rate not to exceed SoCal Gastroenterology regular charges. It is agreed that payment to SoCal Gastroenterology, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such a payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

5. CERTIFICATE. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute this Agreement and to accept its terms.

_____ _____

Date and Time of Signing SIGNATURE - Patient/Guardian/Conservator/Other

_____ _____

Witness If signed by other than patient, indicate relationship