FREC
FRONT RANGE ENDOSCOPY CENTERS, LLC

PEAK
PEAK GASTROENTEROLOGY ASSOCIATES, PC

SCOPE
SURGICAL CENTER OF PEAK ENDOSCOPY, LLC

PATIENT DEMOGRAPHICS

Legal Name: _____ DOB: _____ Age: _____

Address: _____ SSN: _____-_____-_____

City: _____ State: _____ Zip: _____ Email: _____

Phone: (H) _____ (C) _____ Sex: ☐ Male ☐ Female

Marital Status: _____ Race: _____ Primary Doctor: _____

Employer: _____ Referring Doctor: _____

Preferred Language(s): _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Policy Holder, if not patient: _____ DOB: _____ SSN: _____-_____-_____

Secondary Insurance: _____ ID #: _____

Policy Holder, if not patient: _____ DOB: _____ SSN: _____-_____-_____

If patient is under 18 years old, please fill out information regarding parent/guardian accompanying minor child

Name: _____ Relationship: _____ DOB: _____ SSN: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Is your insurance part of the Affordable Care Act (Obamacare)? ☐ ***Yes*** ☐ ***No***

Name: _____ DOB: _____

PATIENT FINANCIAL RESPONSIBILITY FORM

Welcome! We are please you have chosen Peak Gastroenterology Associates, PC (PGA) and Front Range Endoscopy Centers, LLC (FREC). We believe a good doctor/patient relationship is based on understanding and open communication. We are here to make every effort to assist you in management of your account. We hope to avoid any confusion over payment for our professional services by clearly defining our policies at the onset of care. If you have any questions concerning this policy or need further assistance, please contact us immediately.

I give this practice/center my consent to use my protected health information to carry out my treatment, to obtain payment from instance companies, and for health care operations, like minting continuity of care.

I authorize direct payment of benefits to Peak Gastroenterology Associates, PC and Front Range Endoscopy Centers, LLC.

I consent to care, treatment, and diagnostic evaluations performed by the healthcare providers at PGA/FREC.

- It should be noted that my insurance coverage is an agreement between myself and the insurer. It is my responsibility to remit payment for charges not covered by my carrier, and to ensure my carrier remits payment for my account
- If an insurance claim is denied due to incorrect information I have provided, I will be billed and payment in full will be due immediately.
- I have requested medical services from PGA and/or FREC on behalf of myself or my dependents and understand by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized. I understand fees are due and payable on the date services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement.
- As a courtesy to me, PGA/FREC will contact my insurance to check for general eligibility and coverage. It is my responsibility to check if a procedure is covered by my insurance or not, or if it will be applied to my deductible or co-insurance.
- I understand if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.
- As a courtesy to me, PGA/FREC will file all claims with my insurance company. If PGA/FREC do not have a signed contract with my insurance company, or the insurance company fails to pay my claim in a timely manner, the account balance will be transferred to my responsibility. It is then my responsibility to contact the insurance company about processing my claim. I will be required to make payments on my account during this time.
- Each month where there is a balance, I will receive a statement for services, which is due and payable within 30 days of bill date.
- If I am experiencing a set of financial circumstances beyond my control, I will call the billing department at PGA/FREC so they can work with me to make payment arrangements.
- Failure to adhere to the above policies could result in my account being turned over to an outside collection agency. Accounts which maintain a past due balance without payment will be assessed a penalty in the form of interest, collection fees, and/or attorney fees and court costs.
- **Return Check:** A $25.00 fee will be assessed to my account should PGA/FREC receive a returned check for insufficient funds or no account. I will be required to pay the full amount of the check plus the $25.00 fee with cash, money order, or credit card.

If I fail to show for a scheduled clinic appointment, cancel, or reschedule within 24 hours of the appointment, I will be responsible for paying a $50.00 missed appointment fee. If I fail to show for a scheduled procedure, cancel, or reschedule within 48 hours of the procedure, I will be responsible for paying a $250.00 missed procedure fee.

I have read the above financial agreement and agree to abide by the terms set forth in it.

PATIENT'S LEGAL NAME: _____ DOB: _____

Signature: _____ Date: _____

If legally authorized representative, then relationship to patient: _____

Name: _____ DOB: _____

PHONE MESSAGE CONSENT

I give Peak Gastroenterology Associates, PC (PGA) and Front Range Endoscopy Centers, LLC (FREC) permission to leave a phone message regarding my medical care with the following: medical care information including labs, imaging, endoscopy, and other test results as well as appointment times. If I wish to withdraw the consent, I must provide written notice to PGA and FREC stating the date of the requested withdrawal.

My home voicemail: _____

My office voicemail: _____

My cell voicemail: _____

My spouse or other family names and numbers I give permission to leave messages with and/or discuss my medical history:

Name/Relationship: _____/_____ Phone: _____

Name/Relationship: _____/_____ Phone: _____

Name/Relationship: _____/_____ Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICE

Effective April 14, 2003, the Health Insurance Portability and Accountability Act (HIPPA) requires all health care facilities have policies regarding the protection of health information. PGA and FREC have policies in place regarding how we handle and protect the information about health care you receive in our facilities. The following is a summary of our policies regarding our responsibilities and your rights. You may request a copy of this notice at any time. This practice has the right to change its privacy practices and you may obtain any revised notices.

PGA/FREC RESPONSIBILITIES

Must make reasonable effort to keep your health information private and confidential and may NOT release information about you/your health care without your written consent except:

- Internally within our facility or other facility to which we refer you
- To process payment from your insurance company or other funding source
- For health care operations (internal quality management activities, audits, etc.)
- To law enforcement officials (where reporting is required by law) or information provided ot health oversight agencies (i.e. Colorado Department of Health)

YOUR RIGHTS

You have the right to:

- See our policies regarding how we handle your private health information
- Request restrictions on the use or disclosure of your health information
- Inspect and copy your health information
- Request an amendment to your health information

PRESCRIPTION DRUG MONITORING PROGRAM DISCLOSURE

If I receive a prescription for a controlled substance (Schedule II through IV) drug, my identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Program (PDMP) when this drug is dispensed to me. My prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. I have a right to access your information in the PDMP through the Colorado Board of Pharmacy. I may seek corrections to the information as I would my other medical records.

PATIENT'S LEGAL NAME: _____ Signature: _____

If legally authorized representative, then relationship to patient: _____ Date: _____

Name: _____ DOB: _____

PRIOR PROCEDURES

EGD Results: _____ Date: _____

Colonoscopy Results: _____ Date: _____

Sigmoidoscopy Results: _____ Date: _____

Capsule Endoscopy Results: _____ Date: _____

PAST MEDICAL HISTORY: *Please write in ALL medical problems you have*

1)	2)	3)	4)
5)	6)	7)	8)
9)	10)	11)	12)

PAST SURGICAL HISTORY: *Please write in ALL surgeries you have undergone*

1)	2)	3)	4)
5)	6)	7)	8)
9)	10)	11)	12)

FAMILY HISTORY: *Please check the box below for "yes"*

Do family members have a history of:

☐ Celiac Disease	☐ Colon Cancer	☐ Cirrhosis	☐ Pancreatitis
☐ Pancreatic Cancer	☐ Crohn's Disease	☐ Ulcerative Colitis	☐ Stomach Cancer
☐	☐	☐	☐

SOCIAL HISTORY:

Smoking: YES or NO Packs per day: _____ # of Years: _____ Quit Date: _____

Alcohol: YES or NO Beverage and # per day/week: _____ Quit Date: _____

Illicit Drugs: YES or NO Drugs Used: _____ Quit Date: _____

Tattoos: YES or NO Exercise: YES or NO

OTHER PERTINENT INFORMATION

_____

_____

_____

Name: _____ DOB: _____

Pharmacy/Location: _____ Phone: _____

MEDICATIONS

Please list ALL medications you are taking to include over-the-counter medications and herbal supplements. Please do not write “see attached list.”

Prescription Medications

				For Office Use Only	
Name of Medication	Dose	Frequency	Reason for Medication	Continue	Discontinue

Over The Counter Medications or Herbal Supplements

				For Office Use Only	
Name of Medication	Dose	Frequency	Reason for Medication	Continue	Discontinue

ALLERGIES: Please list all your medication allergies

FOR FREC OFFICE USE ONLY

☐ Resume all pre-procedure medications
☐ New medications and instructions
☐ Patient received copy

Name of Medication	Dose	Frequency	Reason for Medication

Ride: _____

Nurse: _____

Physician: _____

Date/Time: _____

Patient Label Here

Name: _____ DOB: _____

REVIEW OF SYSTEMS FOR MALES: Please circle if you are experiencing any of these

CONSTITUTION	EYES	GENITOURINARY	NEUROLOGICAL
Activity Change	Eye Discharge	Difficulty Urinating	Dizziness
Appetite Change	Eye Itching	Pain with Urination	Facial Asymmetry
Chills	Eye Pain	Involuntary Urination	Headaches
Sweats	Eye Redness	Flank Pain	Lightheadedness
Fatigue	Light Sensitivity	Frequent Urination	Numbness
Fever	Vision Changes	Genital Sore	Seizures
Weight Change	**RESPIRATORY**	Blood in Urine	Speech Difficulty
HEENT	Sleep Apnea	Penile Discharge	Passing Out/Syncope
Facial Swelling	Chest Tightness	Penile Pain	Tremors
Neck Pain	Choking	Penile Swelling	Weakness
Neck Stiffness	Cough	Scrotal Swelling	**HEMATOLOGIC**
Ear Discharge	Shortness of Breath	Testicular Pain	Large Lymph Nodes
Hearing Loss	Stridor	Urine Urgency	Easy Bruising/Bleeding
Ear Pain	Wheezing	Decreased Urine	**PSYCHIATRIC**
Ringing In Ear	**CARDIOVASCULAR**	**MUSCULOSKELETAL**	Agitation
Nosebleeds	Chest Pain	Joint Pain	Behavior Problems
Nasal Congestion	Leg Swelling	Back Pain	Confusion
Runny Nose	Palpitations	Gait Problem	Poor Concentration
Postnasal Drip	**GI**	Joint Swelling	Sadness
Sneezing	Abdominal Bloating	Muscle Pain	Hallucinations
Sinus Pressure	Abdominal Pain	**SKIN**	Hyperactive
Dental Problem	Anal Bleeding	Color Change	Nervousness/Anxious
Drooling	Blood in Stool	Pallor	Self-Injury
Mouth Sores	Constipation	Rash	Disturbed Sleep
Sore Throat	Diarrhea	Wounds	Suicidal Thoughts
Trouble Swallowing	Nausea		
Voice Change	Rectal Pain		
	Vomiting		
	Fecal Incontinence		

Physician Signature: _____

Name: _____ DOB: _____

REVIEW OF SYSTEMS FOR FEMALES: Please circle if you are experiencing any of these:

CONSTITUTION	EYES	GENITOURINARY	NEUROLOGICAL
Activity Change	Eye Discharge	Difficulty Urinating	Dizziness
Appetite Change	Eye Itching	Pain During Sex	Facial Asymmetry
Chills	Eye Pain	Pain with Urination	Headaches
Sweats	Eye Redness	Involuntary Urination	Lightheadedness
Fatigue	Light Sensitivity	Flank Pain	Numbness
Fever	Vision Changes	Frequent Urination	Seizures
Weight Change	**RESPIRATORY**	Genital Sores	Speech Difficulty
HEENT	Sleep Apnea	Blood in Urine	Passing Out/Syncope
Facial Swelling	Chest Tightness	Menstrual Problem	Tremors
Neck Pain	Choking	Pelvic Pain	Weakness
Neck Stiffness	Cough	Urinary Urgency	**HEMATOLOGIC**
Ear Discharge	Shortness of Breath	Decrease Urine	Large Lymph Nodes
Hearing Loss	Stridor	Vaginal Bleeding	Easy Bruising/Bleeding
Ear Pain	Wheezing	Vaginal Discharge	**PSYCHIATRIC**
Ringing In Ear	**CARDIOVASCULAR**	Vaginal Pain	Agitation
Nosebleeds	Chest Pain	**MUSCULOSKELETAL**	Behavior Problems
Nasal Congestion	Leg Swelling	Joint Pain	Confusion
Runny Nose	Palpitations	Back Pain	Poor Concentration
Postnasal Drip	**GI**	Gait Problem	Sadness
Sneezing	Abdominal Bloating	Joint Swelling	Hallucinations
Sinus Pressure	Abdominal Pain	Muscle Pain	Hyperactive
Dental Problem	Anal Bleeding	**SKIN**	Nervousness/Anxious
Drooling	Blood in Stool	Color Change	Self-Injury
Mouth Sores	Constipation	Pallor	Disturbed Sleep
Sore Throat	Diarrhea	Rash	Suicidal Thoughts
Trouble Swallowing	Nausea	Wounds	
Voice Change	Rectal Pain		
	Vomiting		
	Fecal Incontinence		

Physician Signature:_____