



719 North Cascade Ave.
Colorado Springs, CO 80903
(719)433-7224



2920 North Cascade Ave.
Colorado Springs, Co 80907
(719)636-1201
and
595 Chapel Hills Dr. Suite 303
Colorado Springs, CO 80920



2920 North Cascade Ave.
Colorado Springs, Co 80907
(719) 362-2300

PATIENT DEMOGRAPHICS

Legal Name: _____ DOB: _____ Age: _____

Address: _____ SSN: _____ - _____ - _____

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

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

Marital Status: _____ Ethnicity/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 (Obama-Care)? Yes No

PATIENT FINANCIAL RESPONSIBILITY FORM

Welcome! We are pleased you have chosen Peak Gastroenterology Associates, PC (PGA), Front Range Endoscopy Centers, LLC (FREC) and Surgical Center of Peak Endoscopy, LLC (SCOPE). We are here to make every effort to assist you in management of your account, and 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 insurance companies, and for health care operations, like maintaining continuity of care.

I authorize direct payment of Medicare, Medicaid or other insurance benefits to Peak Gastroenterology Associates-PC, Front Range Endoscopy Centers- LLC, and Surgical Center of Peak Endoscopy-LLC. If payment is made directly to me, I understand it is my responsibility to send payment to PGA/FREC/SCOPE immediately for services provided.

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

- 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/FREC/SCOPE 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/SCOPE 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/SCOPE will file all claims with my insurance company. If PGA/FREC/SCOPE 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/SCOPE 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. I agree that in the event that my account is turned over to a collection agency or attorney due to non-payment, that I will pay an additional 35% of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collection) plus any court costs and attorney's fees incurred in connection with the collection of my account.
- **Return Check:** A \$35.00 fee will be assessed to my account should there be a returned check for insufficient funds or no account. I will be required to pay the full amount of the check plus the \$35.00 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: _____

PHONE MESSAGE CONSENT

I give Peak Gastroenterology Associates, PC (PGA), Front Range Endoscopy Centers, LLC (FREC), and Surgical Center Of Peak Endoscopy, LLC (SCOPE) 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/FREC/SCOPE 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 (HIPAA) requires all health care facilities have policies regarding the protection of health information. PGA/FREC/SCOPE 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/SCOPE 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 to 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: _____

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:

<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Pancreatic Cancer	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Stomach Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Marijuana: YES or NO Amount per day/week: _____

HX OF/OR CURRENT INFECTIOUS DIAGNOSIS: MRSA VRE C-Diff

OTHER PERTINENT INFORMATION

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

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

Over The Counter Medications or Herbal Supplements

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

ALLERGIES: Please list all your medication allergies

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FOR FREQ/SCOPE 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

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		

THANK YOU FOR CHOOSING PEAK GASTROENTEROLOGY ASSOCIATES!

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
Drizzling	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		

THANK YOU FOR CHOOSING PEAK GASTROENTEROLOGY ASSOCIATES!