FREC
FRONT RANGE ENDOSCOPY CENTERS, LLC
719 North Cascade Ave
Colorado Springs, CO 80903
(719) 433-7224

PEAK
PEAK GASTROENTEROLOGY ASSOCIATES, PC
2920 North Cascade Ave, Ste 300
Colorado Springs, CO 80907
Main Ph (719) 636-1201
&
1370 Interquest Pkwy, Ste 320
Colorado Springs, CO 80921

SCOPE
SURGICAL CENTER OF PEAK ENDOSCOPY, LLC
2920 North Cascade Ave, 1st Floor
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: _____ C i t y :_____ State:_____ Z i p : _____

Is your insurance part of the Affordable Care Act (Obama-Care)? ☐ ***Yes***

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PHONE MESSAGE CONSENT

By providing a telephone number, whether cellular or otherwise, to Peak Gastroenterology Associates, PC (PGA) now or at a later time, I consent to receiving telephone calls, voicemails and/or text messages, or other communication using live, artificial, or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from PGA, and its Affiliates. Affiliates include my health care providers, business associates, agents, contractors, vendors, assigns, successors, servicers, and collection agencies. I certify, warrant, and represent that I am authorized to receive calls at any of the telephone numbers I have provided. The text messages and phone calls may be related to any purpose, including related to my account and my health care, like appointment reminders or offers for additional services. I understand that standard text messaging rates may apply. I agree that PGA and my health care providers may share with Affiliates any telephone number(s) I provide to PGA, so that the Affiliate(s) may make the calls or texts on behalf of PGA or my health care provider. I understand that I may revoke my consent to receive such calls and texts at any time. The callers may leave the name of the company making calls or reference whom the caller is representing. By providing an email address, I give PGA, and Affiliates permission to contact me by email about mine or my dependents' health care or costs related to health care using any email address I provide. Affiliates may use any email address or phone number I give to PGA or that they obtain from me.

Home Phone: _____ **Cell:** _____

Work Phone: _____ **Email:** _____

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:**_____

PATIENT'S LEGAL NAME:_____

Signature: _____

If legally authorized representative, then relationship to patient:_____

Date:_____

PRIOR PROCEDURES

EGD Results:_____ Date: _____

PRIOR PROCEDURES

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

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

				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/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.

DO YOU SUFFER FROM HEMORRHOIDS? YES NO

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:

DO YOU SUFFER FROM HEMORRHOIDS? YES NO

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		

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ACKNOWLEDGEMENT OF RECEIPT 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 the 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 payments from your insurance company or other funding sources
- 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 Dept of Health)

Your Rights

You have the right to:

- See our policies regarding how we handle 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

PATIENT'S LEGAL NAME:_____

Signature: _____

If legally authorized representative, then relationship to patient:_____

Date:_____

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 define 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. A finance charge will be added to balances over 30 days.
- 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 or credit card dispute. 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: _____

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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:_____

Surprise Billing Disclosure

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance**, or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills **could cost thousands of dollars depending on the procedure or service.**

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protection from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk at 1-800-985-3059 regarding federal regulations, or the facilities or agency's billing department: Peak Gastroenterology Associates, 719-636-1201.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

My signature acknowledges receiving this notice and does not waive my rights under the law.

Name of patient: _____

Printed name of person signing for patient:_____

Relationship to patient: _____

Signature of patient or legal authorized representative: _____