Name: _____ Date of Birth: _____

Comprehensive GI Care
A Professional Medical Group, Inc.
Lisa Hertz, MD • Kashyap Trivedi, MD • Pavan Mankal, MD
4772 Katella Ave, Ste 200, Los Alamitos, CA 90720
Phone: (562) 596-5552 • Fax: (562) 596-5340 • Email: cgicare@cgicare.hush.com

Direct Screening Colonoscopy and Consultation Request Form

Please complete our Request form (print/type). You can mail/fax/drop off to our office or email it to our HIPAA-compliant email platform at: cgicare@cgicare.hush.com. Once we receive and review your form, we will contact you for an appointment. Please provide any medical records that pertain to your appointment.

Requesting an appointment with:

- ◯ Dr. Lisa Hertz (not taking new patients)
- ◯ Dr. Kashyap Trivedi (not taking new patient consults, available for screening/surveillance colonoscopies)
- ◯ Dr. Pavan Mankal
- ◯ First Available

Reason for consultation:

- ◯ Screening colonoscopy (To screen for colon polyps and/or colon cancer. I have no symptoms.)
- ◯ Surveillance colonoscopy (I've had polyps before, and I need to check if new ones have grown. I have no symptoms.)
- ◯ I need help for gastroenterological (GI) symptoms (please list below):

_____

_____

Please provide a photo of the following (REQUIRED):

- Photo ID
- Insurance card(s) (front and back)

Have you had:

- ☐ Labs (blood work drawn within the past 1 year)
  Name of laboratory (e.g. Quest Diagnostics, Labcorp): _____
  Date of collection: _____
- ☐ Abdominal imaging (e.g. x-ray, CT, MRI, etc.)
  Name of facility: _____
  Type of imaging (e.g. MRI of abdomen): _____
  Date of test: _____

Name: _____ Date of Birth: _____

MEDICAL HISTORY:

Please check any medical problems that you have or have had in the past.

- ☐ Cirrhosis of liver
- ☐ Crohn's disease
- ☐ Diabetes
- ☐ Fatty liver
- ☐ Gastroesophageal reflux
- ☐ Heart disease / heart attack
- ☐ High blood pressure
- ☐ Sleep apnea
- ☐ Ulcerative colitis

Please list any additional medical problems not noted above.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

MEDICATION LIST:

Please list all medications & supplements, including herbs, vitamins, injections, etc. that you take. List everything even if you take it only occasionally. Please don't forget weekly or monthly meds. If not enough space, please attach a list.

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY
E.g. Atorvastatin	***40 mg***	***1 tablet once a day***	***E.g. Atorvastatin***	***40 mg***	***1 tablet once a day***

Do you take (or are intending to take) GLP-1 agonist medications (e.g. Ozempic, Mounjaro, Wegovy, Zepbound, Trulicity, Rybelsus, etc.) for weight loss or diabetes?

- ◯ Yes
- ◯ No

ALLERGIES:

Please list any allergies you have to medications and the reaction that you have. Also list any other allergies below, such as gluten, grass, shellfish, etc. If not enough space, please attach a list.

NAME	REACTION	NAME	REACTION

Name: _____ Date of Birth: _____

SURGICAL HISTORY:

Please list any surgeries starting from the most recent. If not enough space, please attach a list.

DATE	SURGERY	FACILITY WHERE SURGERY PERFORMED
E.g. MM/YYYY	***Laparoscopic cholecystectomy***	***Los Alamitos Medical Center***

HOSPITALIZATION HISTORY:

Please list any hospitalizations, including inpatient stays and emergency room visits, starting from the most recent. If not enough space, please attach a list.

DATE	REASON FOR HOSPITALIZATION/ER VISIT	HOSPITAL
E.g. MM/YYYY	***Abdominal pain (admitted)***	***Long Beach Medical Center***

COLONOSCOPY AND ENDOSCOPY HISTORY:

Please list all colonoscopies, upper endoscopies (EGD), and flexible sigmoidoscopies, starting from the most recent. If not enough space, please attach a list.

DATE	PROCEDURE	PROVIDER AND FACILITY
E.g. MM/YYYY	***Endoscopy and Colonoscopy***	***Dr. Smith – Long Beach Endoscopy Center***

Name: _____ Date of Birth: _____

FAMILY HISTORY:

Check below the problems that your family members have had.

☐ I don't know my family history.

Do you have?

☐ Multiple family members with colon cancer

☐ Multiple family members with other cancer

	Mother	Father	Siblings	Children
Hepatitis B	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐
Colon Cancer, diagnosed under age 60	☐	☐	☐	☐
Colon Cancer, diagnosed at age 60 or older	☐	☐	☐	☐
Colon Cancer, unsure of age at diagnosis	☐	☐	☐	☐

SOCIAL HISTORY:

Do you currently smoke? ◯ Yes / ◯ No

Have you ever smoked? ◯ Yes / ◯ No

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

Current occupation: _____

REVIEW OF SYSTEMS:

Current weight: _____ Height: _____

Please check if applicable to you.

☐ Chest pain
☐ Irregular heartbeat
☐ Palpitations
☐ Shortness of breath

☐ Abdominal pain
☐ Hemorrhoids
☐ Acid reflux/heartburn
☐ Excessive gas
☐ Dark stools
☐ Excessive belching/bloating
☐ Difficulty swallowing/food stuck in throat/chest
☐ Regurgitation
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Stool accidents/incontinence
☐ Rectal pain/itching
☐ Blood in stool
☐ Decreased appetite

Other symptoms: _____

☐ I do not have symptoms.

Cardiologist Name: _____

Name any gastrointestinal (GI) doctor(s) you have seen in the past: _____

Name: _____ Date of Birth: _____ Gender: ○ F ○ M ○ Non-Binary

PATIENT INFORMATION FORM

Referred by: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ City: _____ Phone: _____

Patient Address: _____ _____ _____ _____ _____
Street Address | Apt. # | City | State | Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Last 4 Social Security #: _____ Employer: _____

Preferred language: ○ English ○ Spanish ○ Other: _____

Marital status: ○ Single ○ Married ○ Widowed ○ Other

Race: ○ American Indian ○ Asian ○ African American ○ Caucasian ○ Hispanic ○ Other: _____

Primary insurance name: _____ Subscriber ID #: _____ Group #: _____

Subscriber name: _____ Relationship to patient: _____ DOB: _____

Insurance Address: _____ _____ _____ _____
Street Address | City | State | Zip

Secondary insurance name: _____ Subscriber ID #: _____ Group #: _____

Subscriber name: _____ Relationship to patient: _____ DOB: _____

Insurance Address: _____ _____ _____ _____
Street Address | City | State | Zip

Emergency contact: _____ Phone: _____

Relationship to patient: _____

Address: _____ _____ _____ _____ _____
(if different) Street Address | Apt. # | City | State | Zip

CONSENT TO TREAT: The undersigned consents to healthcare encompassing routine diagnostic procedures, medical treatment, and other services rendered to the patient by Comprehensive GI Care and/or associates.

NO GUARANTEES: It is understood that the practice of medicine and surgery and the rendering of healthcare is not an exact science. Therefore, no guarantees have been made as to the results of treatments, examinations, or other health services rendered by Comprehensive GI Care and/or associates.

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

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

CERTIFICATION: The undersigned certifies that he/she has read the foregoing, 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.

_____ _____
SIGNATURE – PATIENT/GUARDIAN/CONSERVATOR/OTHER* **DATE***

_____ _____
IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP **DATE**

FINANCIAL POLICY

Thank you for allowing us to participate in your healthcare. We are committed to your treatment being successful and as pleasant as possible.

In the day and age of various health care plans including Medicare, private insurance, and other medical insurance, we understand the medical insurance field can be quite confusing. Please read and sign. Thank you.

1. **MEDICARE PATIENTS:** We are contracted providers with Medicare and accept assignment on all your claims. You are responsible for all deductible and co-insurance balances. If you have a secondary or supplemental insurance, we will be glad to bill as a courtesy to you. If you only have Medicare, your 20% copay is due upon receipt of the Medicare payment. Failure to do so puts your physician in jeopardy with Medicare.
2. **MEDI-CAL AND COVERED CALIFORNIA (OBAMA CARE PLANS/AFFORDABLE CARE ACT**): We are NOT contracted with Medi-Cal and SOME Covered California Plans. Patients with Medi/Medi plans may be responsible for the Medi-Cal portion of the claim, payable at time of service.
3. **PRIVATE INSURANCE:** We bill your insurance as a courtesy. You may be responsible for a percentage of physician's fees as well as your deductible and/or co-insurance. It is the patients' responsibility to be aware of any deductible balance or copay. You may also need authorization to be seen and/or for procedures. If you have any questions, call your insurance company.
4. **COPAYS:** Due at time of service.
5. **MANAGED CARE PLANS:** Because our providers are specialists, you have been referred to us by your primary care provider. You are responsible for ensuring that we have an authorization, if necessary. We are responsible for obtaining future authorizations for any follow-up care.
6. **NO INSURANCE:** Payment in full is due at time of service.
7. **METHODS OF PAYMENT:** We accept cash, check and credit cards. We can also approve a payment plan agreed to by our financial counselor, if necessary.
8. **APPOINTMENTS:** We are happy to re-schedule your appointment. We would appreciate you giving us 24-hour notice. A fee of $50 will be charged if less than 24-hour notice is given for an office visit. If a procedure is cancelled, we require 72-hour notice or $100 will be charged. If you miss three appointments without prior notice, you may be dismissed from the practice.
9. **OPEN ACCOUNTS:** We will do everything possible to make it easy for you to take care of your financial obligations. We would appreciate a phone call in the event you are experiencing financial difficulties and require a payment arrangement.
10. **ASSIGNMENT OF BENEFITS:** You will be asked to sign an assignment of benefits form. If you receive payment, please remit in full to our office to ensure your account can be properly credited.
11. **REQUESTS FOR FORMS/LETTERS:** A fee of $25.00-$50.00 per form will be charged, depending on complexity, for completion of any forms/letters such as disability, family medical leave, jury duty, workers compensation, FAA license, military leave, travel agencies, etc. Your understanding of this necessity is greatly appreciated.

Thank you for trusting us with your care and if you have any questions, please do not hesitate to contact the office.

I have read and understood the above information. I agree to comply with this financial policy.

NAME*	**DATE OF BIRTH***
SIGNATURE*	**DATE***

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I may request a copy of your "Notice of Privacy Practice" containing a complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practice" from time to time and that I may contact this organization at this address above to obtain a copy of the "Notice of Privacy Practice".

I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide by the privacy restrictions stated in your "Notice of Privacy Practice".

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such a sending correspondence to the individual's office instead of the individual's home. This office will generally contact patients by written communication or phone calls. We will send letters to you or call the numbers which you have provided us on your patient information sheet.

Home Telephone

◯ Okay to leave message with detailed information.
◯ Leave message with call-back number only.

Cellphone

◯ Okay to leave message with detailed information.
◯ Leave message with call-back number only.

Work Telephone

◯ Okay to leave message with detailed information.
◯ Leave message with call-back number only.

Home Telephone

◯ Okay to mail to my home address.
◯ Please mail to another address: _____

The Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for uses or disclosures made pursuant to an authorization requested by the individual.

Record of Disclosure of Protected Health Information

I, _____, authorize the office of Comprehensive GI Care to contact the following person(s), such as a Spouse, relative, etc. (**EXCLUDING YOURSELF, PCPs, AND REFERRING MDs**), if needed, regarding my medical information.

NAME	RELATIONSHIP	TELEPHONE NUMBER
NAME	RELATIONSHIP	TELEPHONE NUMBER

PATIENT NAME*	PATIENT SIGNATURE*	DATE*

HIPPA Compliant
Request of the Release of Medical Records

Persons Authorized to Disclose Information (Who records are being requested from)

_____

_____

Person(s) to Whom Information Will Be Disclosed
Information described above may be disclosed to:

Comprehensive GI Care Phone: (562) 596-5552
4772 Katella Ave Ste 200, Los Alamitos, CA 90720 **Fax: (562) 596-5340**

Information to Be Used or Disclosed
The information covered by this authorization includes:

☐ Lab work (last 6 months), other relevant labs (CBC, CMP, CRP, stool studies, IBD panel)
☐ Endoscopy and colonoscopy reports and pathology results
☐ Imaging (relevant CT/MRI scans, abdominal ultrasounds, x-rays)
☐ Consult notes
☐ Other: _____

Purpose of Disclosure
Information listed above will be disclosed for the following purposes:

☐ Continuity of patient care
☐ Other: _____

Expiration Date of Authorization
This authorization is effective through _____ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Privacy Officer at 4772 Katella Ave Ste 200, Los Alamitos, CA 90720.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent.

Rights of the Individual

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

Effect of Refusing Authorization
If you refuse to sign this authorization, the Practice will not deny any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure of others, including: _____

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Signature: _____ **Witness's Signature:** _____

Patient Representative (only if patient is a minor or unable to sign): _____

Relationship: _____ Signature of Patient Representative: _____ Date: _____

Colonoscopy Worksheet (OPTIONAL)
Know What You Will Owe

This informational page is to help patients better understand billing guidelines for colonoscopies and what questions to ask their insurance carrier before the procedure. Do not return this page to the provider with your patient packet, however please use it as a guideline/ worksheet if you choose to contact your insurance. Thank you.

Three categories in which your colonoscopy may fall under:

- **Diagnostic Therapeutic Colonoscopy:**
  Patient has past and/or present gastrointestinal symptoms, polyps, GI disease, or anemia(s).
- **Surveillance/High Risk Screening Colonoscopy:**
  Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a personal history of GI disease, personal and/or family history of colon polyps and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g., every 2 years).
- **Preventative Colonoscopy Screening:**
  Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 45, has no personal or family history of GI disease, colon polyps and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

Who will bill me? You may receive bills for separate entities associated with your procedure, such as the physician, facility, anesthesia, pathologist, and/or laboratory. We can only provide you with information associated with our (physician) fees.

Is the office visit consultation covered for a preventative colonoscopy screening? An office visit prior to a preventative colonoscopy screening is included in the fee for the colonoscopy. If, however, during your office visit, the provider manages a symptom or relevant medical history information, your insurance may be billed for the medical service, and you will be responsible for any applicable copay, coinsurance, and/or your annual deductible.

How will I know what I will owe?
Based on the information above (colonoscopy type patient falls under), please call your insurance carrier and verify the benefits and coverage by asking the following questions.

1. Is the provider an in network or out of network provider?

2. Is the procedure code covered under my policy?

3. Will the procedure be processed as preventative, surveillance or diagnostic and what are my benefits for that service? (Results may vary based on how the insurance company recognizes the diagnosis).
Preventative/Wellness/Routine Colonoscopy Benefits:
Are there age and/or frequency limits for my colonoscopy? (e.g., one every 10 years over the age of 45, one every two years for a personal history of polyps beginning at age 40 etc.)

4. If the physician removes a polyp or takes a biopsy, will this change my out-of-pocket responsibility? (A biopsy of polyp removal or biopsy may change a screening benefit to a diagnostic/ medical necessity benefit which may equal more out of pocket expenses. Carriers vary on this policy.)

Can the physician change, add, or delete my diagnosis so that I can be considered a colon screening? NO! The patient encounter is documented as a medical record from information you have provided. It is binding legal document that cannot be changed to facilitate better insurance coverage.

If your insurance plan has a high deductible and has not been met, you may be asked to make a deposit prior to your procedure.