ARIZONA Gastroenterology
(877) 248-2414 · www.AZGastroenterology.com

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) requires all health institutions to protect the privacy of patient information. HIPAA can impose penalties for covered entities that misuse personal health information. As required by HIPAA, we are providing this notice of our practices to ensure the privacy of your health information and how we may disclose your health information.

We are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations without your written permission. The following is an explanation of each of those services:

1. Treatment means providing, coordinating, or managing health care and related services by one or more of our health care providers. For example, we must share information with your primary care provider.

2. Payment means obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, we must share information with your insurance company to ensure we are paid accurately for our services.

3. Health Care Operations are activities necessary to run our practice. This includes training our employees or providing quality assessments to regulatory agencies.

We will not disclose health information to a family member or friend without your specific written authorization. We may use your demographic information to remind you of an appointment or ask that you call our office by sending postcards and/or leaving messages at home and/or work. We will not leave medical information on answering machines.

We will not use your disclosure for any other purpose without your specific written authorization. This authorization may be revoked at any time by written request.

You have certain rights regarding your protected health information which can be exercised by sending a written request to our office at the address listed below. These rights include:

1. The right to access, inspect and copy your protected health information.

2. The right to request an amendment to your protected health information.

3. The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.

4. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have the right to file a formal written complaint with us at the address below, or with the Department of Health and Human Services, at the address below.

For more information about our Privacy Practices, please contact:

Privacy Officer
Arizona Gastroenterology, Ltd
7566 N. La Cholla Blvd., Suite A
Tucson, AZ 85741
(520) 742-4139

_____ _____
Patient Signature Date

For more information about HIPAA or to file a complaint:

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, DC 20201
(877) 696-6775

ARIZONA GASTROENTEROLOGY, LTD

Frederick Klein, M.D., Gary Monash, M.D., Scott Blinkoff, M.D., J. Patrick Dinning M.D., Leon Tsai, M.D., Bryan Contreras, M.D., Larissa Allen, M.D., Connie Coburn, CNP, Lisa Medeiros, CRNP-F

Patient Payment Policy

We recommend you contact your insurance carrier regarding these charges prior to any services being rendered as it is the responsibility of the patient to obtain coverage and benefit information from their insurance carrier. Any insurance verification we may provide is done as a courtesy and is not a guarantee of benefits, payment or your financial liability.

- **Arizona Gastroenterology, LTD – Physician Services**
  Your financial liability can include your deductible, co-insurance and/or co-payment as determined by your insurance carrier. Copayments are collected at the time of the service. If you do not have your payment your visit will need to be rescheduled.

  If you are being scheduled for a screening colonoscopy, meaning you have no symptoms such as, but not limited to, change in bowel habits, bleeding, anemia or pain, and your doctor finds a polyp or tissue is removed during the procedure, your colonoscopy may no longer be considered a screening. If your procedure changes to a diagnostic colonoscopy your insurance benefits may change.

- **Arizona Gastroenterology, LTD and Boston Scientific (888-581-1201) – Pathology Services**
  If tissue is removed, the specimen must be sent for pathological evaluation. You may receive two bills for this service, one from Arizona Gastroenterology, LTD for the technical component and one from Boston Scientific for the professional component. Your financial liability can include your deductible, co-insurance and/or co-payment, as determined by your insurance carrier.

Self-Pay Policy

- **Arizona Gastroenterology, LTD – Physician Services**
  Payment for office visits are due immediately following your visit payable to Arizona Gastroenterology. Depending on the level of service the fees are: New Patient Visit $120.00 to $331.20, Established Patient Visit $69.60 to $232.00, Hemorrhoid Banding $500.00, Capsule Endoscopy $1500.00. If you do not have your payment at the time of service your appointment will be rescheduled.

- **Arizona Gastroenterology, LTD and Boston Scientific (888-581-1201) – Pathology Services**
  If a biopsy is taken, or polyps are removed, the specimen must be sent for pathological evaluation. You may receive two bills for this service, one from Arizona Gastroenterology, LTD for the technical component and one from Boston Scientific for the professional component.

Cancellation/No Show Policy: We are committed to providing all patients with exceptional care. When a patient cancels without notice, they prevent another patient from being seen. Please notify us within 72 hours of your scheduled appointment if you need to cancel or reschedule. If prior notification is not received, patient will be charged a $25.00 fee per office visit. This will be billed to the patient not to the insurance.

I have read and understand the Patient Payment and Self-Pay Policy.

Patient Signature	Print Patient Name	Date

New/New 3 Year Patient:

Name: _____ When was your last Colonoscopy? _____

Review of Systems: (Please check all that apply)

Constitutional:	Respiratory:	Cardiovascular:	Hematologic:	Immunologic:
___Chills	___Dyspnea	___Chest Pain	___Easy Bruising	___Asthma
___Fever	___Frequent Cough	___Leg Swelling	___Easy Bleeding	___Immunosuppression
___Malaise	___Pleuritic Pain	___Palpitations	___Lymphadenopathy	___Food Allergies
___Weight Loss	___Wheezing			___Seasonal Allergies
				___Chemicals at work

Gastrointestinal:

___Abdomen pain	___Constipation	___Bloody Vomit	___Nausea
___Altered Bowel Habits	___Diarrhea	___Bowel Incontinence	___Rectal Bleeding
___Black Stools	___Decreased Appetite	___Jaundice	___Reflux
___Bloating	___Difficulty Swallowing	___Heartburn	___Vomiting
___Blood in stools	___Excessive Gas	___Painful Swallowing	___Weight Loss

Allergies to medicine and reaction:

_____ _____

_____ _____

_____ _____

Medications: (Please Include Strength and Frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Previous/current medical problems and surgeries:

_____ _____

_____ _____

_____ _____

Social History:

Do you use tobacco? Yes___ No___ How much? _____ Type? _____

Do you use alcohol? Yes___ No___ How Often? _____ Type? _____

Do you use caffeine? Yes___ No____ How often? _____ Type? _____

Have you ever used drugs? Yes ____ No ____ Formerly____ Type? _____

GI Diseases that run in your family:

Father: Alive____ Deceased____ Conditions: _____

Mother: Alive_____ Deceased_____ Conditions: _____

Brother(s): Alive_____ Deceased_____ Conditions: _____

Sister(s): Alive____ Deceased _____ Conditions: _____

Grandparents: Alive_____ Deceased _____ Conditions: _____

Son(s): Alive: _____ Deceased _____ Conditions: _____

Daughter(s): Alive: _____ Deceased: _____ Conditions: _____