ADDC
Alliance Digestive Disease Consultants
Medical Group

www.addcmg.com

50 Alessandro Place, Suite 410 Pasadena, CA 91105
Phone: (626) 793-7114   Fax: (626) 793-7679

The physicians and staff at Alliance Digestive Disease Consultants are dedicated to providing you with personalized and professional care.

Your Primary Care Physician has recommended that you have a colonoscopy. The following packet of information is called the **"Open Access Colonoscopy"** packet.

Please fill out the attached forms and **MAIL BACK** to our office. Please be sure to sign and date all material. When mailing back your packet, please write on the front of the envelope **Attention: Karla**. Note: You may also fax back your information to (626) 793-5968.

The Open Access Colonoscopy Packet includes:

1) A patient information form.
2) A medical history form, which is labeled "Open Access."
3) A medical release form.
4) Our privacy notification (HIPAA)
5) A "Privacy Record of Disclosures" Form, which allows us to know how you would like our physicians to communicate with you when you call our office.

Please also **MAIL** to us the following:

* A copy of insurance card. (Front/Back)
* A copy of your authorization. (If applicable)
* A list of current medications.

Please **CALL** our office **1 week** after mailing in your information. This will provide time for your health information to be reviewed by one of our health care providers to determine whether an office visit is needed prior to having the Colonoscopy. Our Scheduling Department telephone number is **(626) 793-7114 ext. 2**. Please ask to speak to **Karla**. Note: Instructions for the Colonoscopy will be given at the time of your procedure is scheduled.

PATIENT INFORMATION

Please put a check next to the name with whom your appointment is scheduled.
Date:____________________

☐ Kalman Edelman, M.D. ☐ Richard Nickowitz, M.D. ☐ Sassan Soltani, M.D.
☐ Sergio Stubrin , M.D. ☐ Ihab E. Beblawi, M.D. ☐ Peter Rosenberg, M.D.

NAME: ____ Gender: ☐**M** ☐**F** Marital Status: _____________

Phone: ________________________________ Cell Phone: ____

Address: __________________________________ City: ________________________ Zip: _______________

Birthdate: ___________________ **AGE:** __________ Driver's License Number: _____________________________________

Place of Employment: _______________________________ Work Phone: ____________________________

Employment Address: _______________________________City: _________________ State: _____ Zip Code: _________

Occupation: _________________________________ Spouse's Name: _________________________________

In case of emergency notify: ___________________________________ Phone # ______________________

Primary Insurance: ________________ Secondary Insurance: ___________________ ID# ______________

Insurance Company: ___________________________________ Phone Number: ____________________________

Address: ____

City: ___________________________________ State: _____________________ Zip: _________________

Subscriber's Name & Date of Birth : _____________________________ Subscriber Number and Social Securtiy Number: _____________________

Group Number: ____________________ Are You The Subscriber? _______________ Are You A Spouse or Dependent? _______________________

REFERRING PHYSICIAN: _______________________________________ Physician's Phone No: ____________________

Reason for Appointment: ____

Please read and sign: I hereby authorize my insurance benefits be paid directly to Alliance Digestive Disease Consultants Medical Group, and I agree to be financially responsible for non-covered services. I also authorize the physician to release any information to process this claim. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: X____ Regist

Open Access

FOR: ___Colonoscopy or ___UGI endoscopy or ___Both
Name ___________________________________ Today's date _________
Age ____ Height _______ Weight _______ [BMI]
Why are you having this procedure? _______________________________
Have you ever had a colonoscopy before? Yes **or No**
If so, when was it done and what were the findings? _____________
____
Has anyone in your family had colon cancer? Yes or No
If so, who and at what age? __________________________________
Has anyone in your family had colon polyps? Yes or No
If so, who and at what age? __________________________________
Current medications including over-the-counter:
________________ _________________ _______________
____
________________ _________________ _______________

s that you are allergic to? ________________________
Do you have a Latex Allergy? Yes or **No**
Previous operations: ____
Circle any of these medical conditions that you may have:
Heart Disease Angina High Blood Pressure
Asthma or other Chronic Lung Disease Severe Anxiety
Do you take antibiotics prior to dental work? Yes or No **If so, why? _______**
Circle any of the following that you are taking:
Aspirin Coumadin Warfarin Lovenox
Plavix NSAID's (ie. Ibuprofen, Naproxen) Ginkgo
Do you smoke? Yes or No **If so, how much? ____**
How many alcoholic drinks do you have per week? _____
Are you constipated most of the time or have to take laxatives regularly? ____
Do you have any of the following:
Lung disease requiring home oxygen therapy? Yes___ No___
Sleep apnea? Yes___ No___
Recent serious lung problem? Yes___ No___
Recent chest pain with exertion or exercise? Yes___ No___
Heart attack, positive stress test, angioplasty,
or coronary stent within the past 6 months? Yes___ No___
Congestive heart failure or cardiomyopathy? Yes___ No___
ALS or myasthenia gravis? Yes___ No___
Disability requiring wheelchair assistance? Yes___ No___
Diabetes? Yes___ No___
Kidney dialysis? Yes___ No___
Liver Cirrhosis or chronic hepatitis? Yes___ No___

MEDICAL RECORDS RELEASE

TO: ____

DATE: ____

INFORMATION REQUESTED:

Consultation, History & Physical

Procedure and Operative Reports (Please specify): ____________________________

Laboratory and Pathology Reports (Please specify): ____________________________

Imaging Reports (Please specify):
____

Physician Correspondence/ Letters:
____

Other:
____
____
____
____

Patient Name (Printed) Date of Birth

RELEASE
I hereby authorize the release of my health information. I understand that this authorization is voluntary that all records are confidential and cannot be released without my prior authorization except as otherwise allowed by law. I understand that a photocopy or fax of this authorization is as valid as the original. This authorization expires in one year.

____
____

SIGNATURE DATE OF AUTHORIZATION
____
____
Name of Patient Representative, if other than patient Relationship

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT,

PAYMENT, AND HEALTH CARE OPERATIONS

I, ________________________________, hereby authorize Alliance Digestive Disease Consultants Medical Group, to use and /or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations.

I have been informed that Alliance Digestive Disease Consultants Medical Group has prepared a notice ("NOTICE") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Alliance Digestive Disease Medical Group, in writing, but if I revoke my consent, such revocation will not affect any actions that Alliance Digestive Disease Consultants Medical Group took before receiving my revocation.

I understand that Alliance Digestive Disease Consultants Medical Group has reserved the right to change his/ her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Alliance Digestive Disease Consultants Medical Group restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Alliance Digestive Disease Consultants Medical Group does not have to agree to such restrictions, but that once such restrictions are agreed to, Alliance Digestive Disease Consultants Medical Group must adhere to such restrictions.

_______________________________________ ___________________

Signature of patient or patient's representative **Date**

(Form must be completed before signing)____

Printed name of patient or patient's representative

_____________________________________ **Relationship to the patient**

Addc.acknofnotice.consent

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

Home phone ____________________Written Communication

_ OK to leave message with detailed information

_ OK to mail to home address

_ Leave message with call back number only

_ OK to mail to work address

_ OK to fax to this phone

Work phone # ____________________

____

OK to leave message with detailed information

Other (Please specify)

____

____

____

Patient signature __________________________
Date __________________________

Print name ______________________________

Date of Birth ____________________________

Addc.patientrecordofdisclosures