Open Access Forms - Introduction

Thank you for choosing us to perform your procedure. The following forms are necessary to determine your eligibility for an open access procedure. Please fill them out to the best of your ability and sign or initial all highlighted areas. Should you need any assistance, please do not hesitate to contact us and we will gladly guide you.

Please return this form to our office by one of the following methods:

- Email to info@centergihealth.com
- Fax to 310-742-0444
- Mail to 9730 Wilshire Blvd. #115, Beverly Hills, CA 90212

Please include a copy of your health insurance card (front and back) and a copy of your driver's license.

Within 48 hours of the receipt of this information, our office will contact you to determine your eligibility for open access. We look forward to serving your medical needs.

Sincerely,

Dr. Nowain and staff at the Center for GI Health

Table of Contents

PATIENT INFORMATION

Please print clearly and legibly

Full (legal) Name: _____ Date: _____

Date of Birth:_____ SS#: _____ Driver's License #_____

Home Address: _____

City: _____State: _____ Zip: _____

Phone #:_____ ❑ Married ❑ Single ❑ Other: _____

❑ Male ❑ Female

Occupation: _____

Employer: _____

Email: _____

Would you be interested in receiving our quarterly patient newsletter? ❑ Yes ❑ No

EMERGENCY CONTACT:

Name: _____ Phone #: _____

Relationship: _____

REFERRALS

How did you hear about us?

❑ Google ❑ Yelp ❑ YellowPages.com ❑ Avvo.com ❑ Word of Mouth

❑ La Peer Health Systems / Surgery Center / LaPeerHealth.com

❑ Other Internet Website: _____

❑ Insurance company (please give name): _____

❑ Another patient (please give name): _____

❑ Another Physician - Name: _____

Phone #:_____ Physician Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Co. Name: _____

Name: _____

Subscriber's Name: _____

Policy #: _____

Group #: _____

SECONDARY INSURANCE

Insurance Co. _____

Name: _____

Subscriber's Name: _____

Policy #: _____

Group #: _____

Attestation: I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Dr. Nowain of any changes in my status or the above information.

Assignment of Benefits: I hereby authorize Arash Ari Nowain, M.D. to furnish the information to my insurance carriers.
I hereby irrevocably assign Arash Ari Nowain, M.D. all payments for services rendered and all major medical benefits.

Consent for Treatment: I hereby authorize my consent to be treated now and in the future by Arash Ari Nowain, M.D.

PATIENT: _____ _____

Signature Date

Insurance Policies

NON-ACCEPTANCE OF HMO & MEDI-CAL INSURANCE FOR PATIENTS WITH MEDICARE / MEDI-CAL BENEFITS

I have been informed that Medi-Cal and all HMO Insurances are not accepted as a method of payment for services rendered by Arash Nowain, M.D. I am also aware that Arash Nowain M.D accepts only Medicare, Private Insurances and Cash.

By signing this waiver, I agree and understand that after Medicare reimburses for the medical services, I am financially liable for the fees that will not be allowed by Medi-Cal. Furthermore, I am giving my full consent to Arash Ari Nowain M.D. to send me a detailed account statement indicating the medical services with the corresponding charges. I will send my payment to Arash Ari Nowain M.D. thereafter. **Initials** _____

Office Appointment Cancellation Policy

We are proud of the high quality of care we deliver and spend as much time with patients as they need. In order to maintain the efficiency of our practice while accommodating all of our patients, we see patients by appointment. We ask that you respect our time by cancelling an appointment when you find you cannot make it, and we ask that you give us at least one day's notice. **Any cancellations made with less than one day's notice will be charged $50.00**. Please initial below to indicate you have read, understand, and agree to the above conditions. **Initials** _____

Procedure Cancellation Policy

Due to significant number of cancellations made within 72 hours of the procedure time, we have instituted a cancellation policy. Cancellations for endoscopic procedures including Upper GI Endoscopy and/or Colonoscopy must be made at least 72 hours prior to the scheduled procedure (or by Thursday for Monday procedures). **Any cancellations made with less than 72 hour notice will be charged $250.00**. Please initial below to indicate you have read, understand, and agree to the above conditions. **Initials** _____

Office Visit/Procedure Payment Policy

Patients are responsible for any services not covered by patient insurance plan. If we must take legal and or collections action to get outstanding balances paid, patient will be responsible for any additional charges. **Initials** _____

Please sign below to indicate you have read, understand, and agree to all the above listed policies and conditions.

_____	_____	_____
Signature	Print Name	Date

Office Policy Form Rev. 10/24/11

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of ARASH NOWAIN M.D. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:
1. the right to request restrictions on the use and disclosure of your protected health information
2. the right to receive confidential communications concerning your medical condition and treatment
3. the right to inspect and copy your protected health information
4. the right to amend or submit corrections to your protected health information
5. the right to receive an accounting of how and to whom your protected health information has been disclosed
6. the right to receive a printed copy of this notice

ARASH NOWAIN MD, Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting THE Medical Records Clerk or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:
Privacy Officer
ARASH NOWAIN, M.D..
9730 Wilshire Blvd. #115
Beverly Hills, CA 90212
If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is:
Privacy Officer
ARASH NOWAIN, M.D..
9730 Wilshire Blvd. #115
Beverly Hills, CA 90212
(310) 657-4444

Effective Date. This notice is effective on or after July 1, 2008

Acknowledgement of Receipt of Notice of Privacy Practices

Arash Ari Nowain, M.D. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Arash Nowain, M.D.

_____ _____

Name of Patient Date

_____

Signature of Patient

_____

Signature of Patient Representative (required only if patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

OFFICE USE ONLY BELOW THIS LINE

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of Notice of Privacy Practices on

_____.
Date

The acknowledgement was not obtained because:

- The patient declined to sign the acknowledgment
- The patient was undergoing emergency treatment
- Other_____

Signature: _____

Name of Staff:_____

Name of Patient: _____

Date: _____

CENTER FOR GI HEALTH

Center for GI Health

PATIENT E-MAIL CONSENT FORM

Patient name: _____

E-mail: _____ (please print clearly and legibly)

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a) **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Dr. Nowain and the Practice are not encrypted, so E-mails may not be secure.** Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) E-mail senders can easily misaddress an E-mail.
d) E-mail is easier to falsify than handwritten or signed documents.
e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail can be used to introduce viruses into computer systems.
Practice server could go down and E-mail would not be received until the server is back on-line.

i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. Practice and Physician cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.
b) If the patient's E-mail requires or invites a response from Practice or Physician, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond.
c) E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
d) All E-mail will usually be printed and filed in the patient's medical record.
e) Office staff may receive and read your messages.
f) Practice will not forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g) The patient should not use E-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.
j) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by E-mail with Practice.

Center for GI Health

PATIENT E-MAIL CONSENT FORM

3. INSTRUCTIONS

To communicate by E-mail, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the E-mail.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Practice of changes in his/her E-mail address.
e) Acknowledge any E-mail received from the Practice and/or Physician.
f) Take precautions to preserve the confidentiality of E-mail.
g) Protect his/her password or other means of access to E-mail.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge **Center for GI Health** and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature_____

Date_____

Witness signature_____

Date_____

Open Access Medical History Questionnaire

1. Full (legal) Name: _____

2. Date of Birth: _____/_____ /_____

3. Please check one: ❑ New patient ❑ Existing patient

4. Procedure requested: ❑ Colonoscopy ❑ Upper endoscopy (EGD) ❑ Colonoscopy + EGD

5. Reason for requesting the above listed procedure:

_____

_____

6. Have you previously undergone a colonoscopy and/or upper endoscopy (EGD)? ❑ Yes ❑ No

If yes, please describe when and briefly describe the findings (if known):

_____

_____

7. Do you suffer from any of the following symptoms?

❑ Diarrhea	❑ Heartburn / acid reflux	❑ Nausea and or vomiting
❑ Constipation	❑ Abdominal pain	❑ Iron deficiency
❑ Change in bowel habits	❑ Abdominal bloating	❑ Vitamin B12 deficiency
❑ Blood in stool	❑ Difficulty swallowing	❑ Unintentional weight loss

❑ Other symptoms (please explain) _____

8. Do you have any medical conditions? ❑ Yes (please list them below) ❑ No

_____

_____

9. Have you had any prior surgeries? ❑ Yes (please list them below) ❑ No

_____

_____

Full (legal) Name: _____

10. Have you had any prior issues / problems with anesthesia? ❑ Yes (please explain below) ❑ No

_____

11. Are you currently taking any medications? ❑ Yes (please list them below) ❑ No

_____

_____

12. Is there any family history of colon cancer or colon polyps? ❑ Yes ❑ No

If yes, please explain their relation to you and the age at which they were diagnosed below:

_____

_____

13. Is there anything specifically that you would like to have addressed by the doctor prior to your procedure?

_____

_____

Thank you for taking the time to fill out this questionnaire.
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Please include a copy of your health insurance card (front and back) and a copy of your driver's license.

Within 48 hours of the receipt of this information, our office will contact you to determine your eligibility for open access.

Sincerely,
Dr. Nowain and staff at the Center for GI Health