

**New Patient Intake Form**

**Patient Name:**

\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Gender:** \_\_\_\_\_

**Street Address:**

\_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Telephone Number:**

\_\_\_\_\_

**Email:** \_\_\_\_\_ **Occupation:**

\_\_\_\_\_

**Insurance Information**

**Insurance Provider:**

\_\_\_\_\_

**Policy Number:**

\_\_\_\_\_

**Group Number:**

\_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Relationship to Policy Holder:** \_\_\_\_\_

**Secondary Insurance Information**

**Insurance Provider:**

\_\_\_\_\_

**Policy Number:**

\_\_\_\_\_

**Group Number:**

\_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Relationship to Policy Holder:** \_\_\_\_\_

**Emergency Contact**

**Name:**

\_\_\_\_\_

**Relation to you:** \_\_\_\_\_ **Telephone Number:**

\_\_\_\_\_

**Consent to Treatment**

This purpose of this consent form is to obtain your permission to perform the evaluation necessary to identify any condition(s) that might require treatment as part of your plan of care. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

I voluntarily request a provider, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified.

You have the right to be informed about any condition identified and any/all recommended treatments including, but not limited to, imaging, labs, referrals. You may then decide whether or not to undergo any suggested treatment after being informed of the potential risks, benefits, and alternatives involved.

I agree to healthcare communication via email, phone call and or text messages. I understand I may opt out of text and or email messaging by notifying any staff member.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign an additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I understand I am responsible for additional fees that may occur.

If signing as a parent or guardian, I hereby represent that I am legally empowered to make such decisions.

By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**What is the reason you are being seen? \_\_**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Colonoscopy for screening | <input type="checkbox"/> Abdominal pain     | <input type="checkbox"/> Acid reflux/GERD      | <input type="checkbox"/> Painful/Difficult swallowing |
| <input type="checkbox"/> Bloating/Gas              | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Rectal bleeding       | <input type="checkbox"/> Change in bowel habits       |
| <input type="checkbox"/> Constipation              | <input type="checkbox"/> Blood in the stool | <input type="checkbox"/> Abnormal imaging/labs | <input type="checkbox"/> Nausea/Vomiting              |

Other: \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_

**Who is your primary care physician?** \_\_\_\_\_

**What is your preferred pharmacy?** \_\_\_\_\_

### Medical History

**Do you have, or have you had, any of the following medical problems?**

Gastrointestinal

- IBS (Irritable Bowel Syndrome)
- GERD/Heartburn
- H pylori infection
- Stomach or intestinal ulcer
- Colon polyps
- Diverticulitis
- Gallstones
- Crohn's disease or ulcerative colitis
- Pancreatitis
- Celiac Disease
- GI bleeding
- Chronic constipation
- Other:

Cardiac Disease

- Hypertension/high blood pressure
- Coronary artery disease
- Heart attack
- Chest pain
- Congestive heart failure
- Atrial fibrillation or arrhythmia
- High cholesterol
- Heart valvular disease
- Other:

Neurologic:

- Stroke(s)

Liver

- Cirrhosis
- Hepatitis B
- Hepatitis C
- Elevated liver tests
- Jaundice
- Fatty liver disease
- Other:

Respiratory/Pulmonary

- COPD or emphysema
- Asthma
- Obstructive sleep apnea
- Other:

Psychological

- Bipolar Disorder
- Anxiety
- Depression
- Schizophrenia
- Other:

Kidney/Renal

- Kidney stones
- Chronic kidney disease
- Other:

Cancer

- Colon cancer
- Stomach cancer
- Esophageal cancer
- Breast cancer
- Prostate cancer
- Liver Cancer
- Leukemia
- Other cancers:

Endocrine

- Type 1 diabetes
- Type 2 diabetes
- Hypothyroidism
- Hyperthyroidism
- Other:

Blood/Bleeding Disorders

- Hemophilia
- Clotting Factor deficiencies
- Von Willebrands Disease
- Other:

- Seizure disorder
- Migraines
- Headaches
- Other:

**Are there any other medical problems that you would like us to know about:**

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**Surgical History** (please list all operations that you have had, including the year):


**Medication Allergies:**


Do you currently smoke cigarettes? \_\_\_\_\_

Have you smoked cigarettes in the past? If so, when did you quit? \_\_\_\_\_

How many alcoholic beverages, if any, do you drink per week? \_\_\_\_\_

Do you currently smoke or ingest marijuana? \_\_\_\_\_

Have you used any illicit drugs in the past? \_\_\_\_\_

**Do you have a family history of any of the following conditions?**

<ul style="list-style-type: none"> <li><input type="checkbox"/> Crohn's Disease</li> <li><input type="checkbox"/> Ulcerative Colitis</li> <li><input type="checkbox"/> Celiac Disease</li> <li><input type="checkbox"/> Colon Polyps</li> <li><input type="checkbox"/> Colon or Rectal Cancer</li> <li><input type="checkbox"/> Stomach cancer</li> <li><input type="checkbox"/> Esophageal cancer</li> <li><input type="checkbox"/> Pancreatic cancer</li> <li><input type="checkbox"/> Small intestinal cancer</li> </ul>	<p><u>Family Member</u></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Liver disease</li> <li><input type="checkbox"/> Hemochromatosis</li> <li><input type="checkbox"/> Pancreatitis</li> <li><input type="checkbox"/> Breast cancer</li> <li><input type="checkbox"/> Uterine cancer</li> <li><input type="checkbox"/> Cervical cancer</li> <li><input type="checkbox"/> Other:</li> </ul>	<p><u>Family Member</u></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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Please list all medications which you are currently taking (with dosage):

Blank lines for listing medications and dosages.

I hereby certify that the information provided above is true and accurate to the best of my knowledge. I understand that it is my responsibility to inform the medical practice of any changes to my health or personal information.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

1. Uses and Disclosures of Health Information

We may use and disclose your health information for treatment, payment, and healthcare operations:

- Treatment: We may use your health information to provide, coordinate, or manage your healthcare and related services.
Payment: We may use your health information to obtain payment for services we provide, including billing and collections.
Healthcare Operations: We may use your health information to perform activities necessary for our practice to operate efficiently.

2. Other Uses and Disclosures

We may also use or disclose your health information in the following situations:

- Required by Law: We will disclose your health information when required to do so by federal, state, or local law.
Public Health Activities: We may disclose your health information for public health purposes, such as reporting disease outbreaks or preventing injury.
Health Oversight Activities: We may disclose your health information to health oversight agencies for activities authorized by law, such as audits or investigations.
Judicial and Administrative Proceedings: We may disclose your health information in response to a court order or subpoena.

3. Your Rights

You have the following rights regarding your health information:

- Right to Access: You have the right to inspect and obtain a copy of your health information.
Right to Request Amendments: You have the right to request that we amend your health information if you believe it is incorrect or incomplete.
Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we have made of your health information.
Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information.
Right to Confidential Communications: You have the right to request that we communicate with you in a certain way or at a certain location.

4. Changes to This Notice

We reserve the right to change this notice and make the new notice effective for all health information we maintain. We will post a copy of the current notice in our office.

5. Contact Information

If you have questions or complaints about this notice or our privacy practices, please contact:

Kenneth Pugh
310-652-4472
admin@innovativegi.com

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Telemedicine Consent Form**

**1. Introduction**

Telehealth refers to the use of electronic communications to provide and facilitate healthcare services at a distance. This may include virtual visits, video calls, phone consultations, and other forms of electronic communication.

**2. Consent to Participate in Telehealth**

I understand that:

- I have the right to refuse telehealth services and request an in-person visit instead.
- Telehealth services may involve the use of technology to connect with healthcare providers remotely.
- There may be risks associated with the use of telehealth, including but not limited to technical failures, interruptions, and unauthorized access to information.

**3. Privacy and Confidentiality**

I understand that all telehealth services are subject to the same privacy and confidentiality standards as in-person visits. My healthcare provider will take steps to protect my privacy and the confidentiality of my health information.

**4. Use of Technology**

I agree to participate in telehealth services using the following technology:

- Video conferencing platform (e.g., Zoom, Doxy.me)
- Phone call

**5. Emergency Situations**

I understand that telehealth services are not suitable for emergencies. In case of a medical emergency, I will call 911 or go to the nearest emergency room.

**6. Consent to Treatment**

By signing this form, I consent to receive telehealth services from [Your Practice Name]. I have had the opportunity to ask questions about telehealth, and my questions have been answered to my satisfaction.

**7. Signature**

By signing below, I acknowledge that I have read and understood this Telehealth Consent Form, and I voluntarily consent to participate in telehealth services.

**Patient/Guardian Signature:** \_\_\_\_\_

Date: \_\_\_\_\_



**HIPAA Release Form**

1. Authorization

I, the undersigned, hereby authorize Cameron Sikavi, MD to use and disclose my protected health information (PHI) as described in this release form.

2. Recipient Information

I authorize the release of my PHI to the following individual or entity:

Name: Cameron Sikavi, MD

Address: 8631 W 3<sup>rd</sup> Street Suite 1015-E Los Angeles, CA 90048

Phone Number: 310-652-4472

Email (if applicable): [admin@innovativegi.com](mailto:admin@innovativegi.com)

3. Purpose of Disclosure

The purpose of this disclosure is:

- Continuing medical care
- Legal purposes
- Insurance purposes

4. Information to Be Released

I authorize the release of the following information:

- Complete medical record
- Specific records (please specify): \_\_\_\_\_

5. Expiration of Authorization

This authorization will expire on: \_\_\_\_\_

(If no date is specified, this authorization will expire one year from the date signed.)

6. Right to Revoke

I understand that I have the right to revoke this authorization at any time by submitting a written request to Cameron Sikavi, MD. The revocation will not affect any actions taken prior to the receipt of the revocation.

7. Acknowledgment

I understand that my information may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

8. Signature

By signing below, I acknowledge that I have read and understood this HIPAA Release Form and voluntarily consent to the use or disclosure of my health information as described above.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Cancellation Policy**

Due to the specialty nature of our practice, and the limited number of patient visits available per week, we are enforcing a 24 hour cancellation policy for all patients. We respect your time and appreciate your respect in return.

If you have made a Monday appointment and you need to cancel or reschedule your appointment, please call us by 4:30 PM on the Friday before the appointment.

Unfortunately, cancellations on Saturday and Sunday via voicemail will not be possible as we are out of the office. If your appointment falls on the day after a three or four day holiday weekend and you need to cancel or reschedule your appointment, we request that you do so prior to 4:30 PM on the day before the holiday weekend begins or you will be responsible for the cancellation fee.

**Exceptions and Charges:**

If there is an opening in the same week as your cancellation and you can not come in at that time, you will not be charged for the missed appointment.

If a patient fails to show up for their visit with no notice of cancellation, they will be charged the full amount for the visit.

If you cancel your rescheduled appointment, you will be charged.

When booking an appointment, whether you are a new patient or an existing patient, we will need to hold a credit card on file. It will not be charged until after your missed appointment.

The amount that will be charged for a missed appointment, or not giving us 24 hour prior notice, is \$100. There are no exceptions.

**Procedure Cancellation**

Procedures are scheduled with staffing of an anesthesiologist, three registered nurses, and a GI technician, so late cancellations are a problem. Cancellations for endoscopic procedures, including Upper GI endoscopy, Colonoscopy, Endoscopic Ultrasound, and ERCP, must be made at least 3 days prior to the scheduled procedure (i.e. Monday for a Thursday procedure). We request that you please contact us as soon as possible if you are unable to make a scheduled procedure appointment.

Any cancellation made within less than 3 business days notice will be charged \$200.

Please sign below indicating that you have read and understand the 24-hour cancellation policy for outpatient visits, the 72-hour cancellation policy for outpatient procedures, and agree to the terms outlined above.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Assignment of Benefits Form**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor/ambulatory surgery center and is not a substitute for payment. Some companies have fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for you by your insurance. If the account is not paid in full and prior arrangements have not been made, your account(s) may be referred to a collection Agency. In the event that your account is referred to an Agency, you will be responsible for all attorney's and/or collection fees. I directly assign all medical/surgical benefits to Cameron Sikavi MD, Inc. and understand that I am financially responsible for all charges not covered by my insurance benefits.



I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If I receive a check from my insurance, I agree to immediately endorse the back of the check to Cameron Sikavi MD Inc. and send it to the medical office at 8631 West Third Street Suite 1015-E Los Angeles, CA 90048. I understand that this Entity requires Advance Payment for certain in-office and outpatient procedures. As a patient, I am required to be familiar with my Insurance coverage and its policies and know my co-pay, coinsurance, deductible, total out of pocket expense, effective date of coverage, pre-existing conditions AND whether I am receiving service from a contracted or out-of-network physician or other healthcare provider/facility. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I have read and understand the information on this form. I certify the information is true and correct to the best of my knowledge.

**I have reviewed the above Policies & Agreements and hereby agree to comply with ENTITY Policies**

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_