Innovative GI

New Patient Registration

Please Complete All Sections Prior to Your Visit

Patient Information

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

(If applicable)

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

The 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 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, and 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 message. I understand I may opt out of text and/or email messaging by notifying any staff member.

I understand that if additional testing or invasive or interventional procedures are recommended, I will be asked to read and sign 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 any additional fees that may occur.

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

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

Signature: _____ **Date:** _____

Reason for Visit

What is the reason you are being seen?

- ☐ Colonoscopy for screening
- ☐ Acid reflux/GERD
- ☐ Bloating/gas
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Abnormal imaging/labs
- ☐ Abdominal pain
- ☐ Painful/difficult swallowing
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Blood in the stool
- ☐ 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)
- ☐ Seizure disorder
- ☐ Migraines
- ☐ Headaches
- ☐ Other:

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 Willebrand's disease
- ☐ Other:

Are there any other health-related issues you'd like us to know about?

_____

_____

Surgical History

Please list all operations you have had, including the year.

1. _____
2. _____
3. _____
4. _____
5. _____

Medication Allergies

1. _____
2. _____
3. _____
4. _____
5. _____

Social History

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?

Family History

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

	Family Member		*Family Member*
☐ Crohn's disease		☐ Liver disease	
☐ Ulcerative colitis		☐ Hemochromatosis	
☐ Celiac disease		☐ Pancreatitis	
☐ Colon polyps		☐ Breast cancer	
☐ Colon or rectal cancer		☐ Uterine cancer	
☐ Stomach cancer		☐ Cervical cancer	
☐ Esophageal cancer		☐ Other:	
☐ Pancreatic cancer			
☐ Small intestinal cancer			

Current Medications

Please list all medications you are currently taking, with dosage.

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

I hereby certify that the information provided above is true and accurate to the best of my knowledge. I understand it is my responsibility to inform the 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 this HIPAA Notice of Privacy Practices and any subsequent changes to 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 Innovative GI. 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 3rd St, Suite 1015-E, Los Angeles, CA 90048

Phone Number: (310) 652-4472

Email: 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 enforce 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 need to cancel or reschedule, please call us by 4:30 PM on the Friday before the appointment. Unfortunately, cancellations left by voicemail over the weekend are not 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, please do so before 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 the same week as your cancellation and you're able to come in at that time, you will not be charged for the missed appointment.
- If a patient fails to show up for a visit with no notice of cancellation, they will be charged the full amount for the visit.
- If you cancel a rescheduled appointment, you will also be charged.
- When booking an appointment, whether you are a new or existing patient, we will need to hold a credit card on file. It will not be charged unless you miss an appointment.

The charge for a missed appointment, or for not giving at least 24 hours' notice, is $100. There are no exceptions.

Procedure Cancellation

Procedures are staffed by an anesthesiologist, three registered nurses, and a GI technician, so late cancellations are a significant problem. Cancellations for endoscopic procedures — including upper GI endoscopy, colonoscopy, endoscopic ultrasound, and ERCP — must be made at least 3 business days prior to the scheduled procedure (for example, by Monday for a Thursday procedure). Please contact us as soon as possible if you're unable to make a scheduled procedure appointment.

Any cancellation made with 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 and the 3-business-day cancellation policy for outpatient procedures, and that you 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 or 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, coinsurance, or other balance not covered by your insurance. If your account is not paid in full and prior arrangements have not been made, your account may be referred to a collection agency. In the event that your account is referred to an agency, you will be responsible for all attorneys' and/or collection fees. I directly assign all medical/surgical benefits to Innovative GI (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 directly to the provider. If payment is made to the policyholder instead, I agree to submit payment in full to this office immediately. If I receive a check from my insurance, I agree to immediately endorse it to Innovative GI (Cameron Sikavi, MD, Inc.) and send it to our office at 8631 W 3rd St, Suite 1015-E, Los Angeles, CA 90048. I understand that the practice 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, including my co-pay, coinsurance, deductible, total out-of-pocket expense, effective date of coverage, pre-existing conditions, and whether I am receiving services 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 payment 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, and I certify that it is true and correct to the best of my knowledge.

I have reviewed the above policies and agreements and hereby agree to comply with Innovative GI's policies.

Patient/Guardian Signature: _____ **Date:** _____

On File Credit Card Authorization Form

Our financial policy requires all patients to maintain a credit card or debit card on file with our practice. Our office submits your claim to your insurance and sends out monthly statements. If your balance has not been paid, the card on file will be charged once your account is more than 90 days overdue. Your card may also be charged fees as detailed in our Cancellation Policy.

Please complete the information below:

Patient Name: _____

Date of Birth: _____

Card Type:

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Cardholder Name: _____

Credit Card Number: _____

Expiration Date: _____

CVV2 (back of Visa/MC, front of AmEx): _____

Billing Address: _____

City, State, ZIP: _____

By signing below, I authorize Innovative GI (Cameron Sikavi, MD, Inc.) to charge the credit card or debit card indicated above, according to the terms outlined here; the card provided will only be charged for a full balance if/when my account becomes more than 90 days delinquent. I certify that I am an authorized user of this card, and that I will not dispute the charge with my card company so long as the transaction corresponds to the terms indicated in this form.

Patient/Guardian Signature: _____ **Date:** _____