MEDICAL HISTORY

Name_____________________________ DOB_________ Pharmacy Name, Location__________________________
Reason for Visit___________________________________ Physician____
Medications, Dose, Frequency____
____
Allergies_____________________________

MEDICAL HISTORY

__Anemia
__Colon Polyps
__Colon Cancer
__Cancer
__Ulcers
__Reflux
__Barrett's Esophagus
__Ulcerative Colitis
__Crohn's Disease
__Irritable Bowel Syndrome
__Hepatitis C
__High Blood Pressure
__Diabetes
__Jaundice
__High Cholesterol
__Osteoarthritis
__Rheumatoid Arthritis
__Fibromyalgia
__Stroke
__COPD/Emphysema
__Sleep Apnea
__Tuberculosis
__Seasonal Allergies
__Thyroid Disease
__Heart Disease
__Congestive Heart Failure
__Atrial Fibrillation
__Heart Valve Disease
__Pacemaker/Defibrillator
__Blood Clots
__Valve Replacement
__Bleeding Disorder
__Blood Transfusion
__Osteoporosis
__Kidney Failure
__Urinary Infections
__AIDS
__Hepatitis B
__Headaches
__Gallstones
__Kidney Stones
__Asthma
__Depression
__Anxiety
__Seizure Disorder
__Glaucoma
__Alcohol__Social__Heavy__
__Tobacco
__Substance Abuse
__Tattoos
__Piercings
__Anesthesia Problems
__Dentures__Full__Partial__

SURGERIES

__Gall bladder
__Appendix
__Stomach
__Colon
__Thyroid
__Hysterectomy
__Orthopedic
__Mastectomy
__Prostate
__Hernia
__Radiation
__Heart Bypass
__Heart Stent
__Cosmetic
__Other

FAMILY HISTORY __Adopted

__Colon Cancer
__Colon Polyps
__Stomach Cancer
__Liver Disease
__Crohn's Disease
__Gallbladder Disease
__Pelvic Cancer
__Breast Cancer
__Anemia
__Cirrhosis
__Ulcerative Colitis
__Other

SOCIAL HISTORY

__Retired
__Occupation
__Coffee, Soda__

ENDOSCOPY HISTORY

__EGD_____________
__Colonoscopy______

RECENT TEST

__Abdominal XRAY/CT/MRI/US
__Blood Work
__Stool Card

PATIENT INFORMATION

Please fillout this form **COMPLETELY** to allow us to process your insurance. **Thank you** ☺

Patient's Name____ Responsible Party Name________________________________
Primary Language Spoken: English / Spanish / Other____
Billing Address____ City, State, Zip___________________________________
Home Phone_________________________ Business Phone________________________ Cell Phone________________________
Sex: Male / Female Age___________ Birth Date (MM/DD/YYY)_______________________________

Patient S.S. #_______________________________________
Responsible Party S.S. #____ Relationship to Patient__________________________
Referring Doctor's Name & Address____

Primary Care Doctor Name & Address____
Is injury related to an accident? YES / NO Auto accident or job-related injury? YES / NO
Date of injury__________________

Is Patient: Single / Married / Other Is Patient: Employed / Full Time Student / Part Time Student / Other

Employer Name/Address/Phone Number____
Spouse or nearest relative Name/Address/Phone Number____
____

Name of **Primary** Insurance_________________________ Name of **Secondary** Insurance________________________

Policy Holder Name_______________________________ Policy Holder Name_________________________________

Relationship to Patient_____________________________ Relationship to Patient______________________________

Employer_______________________________________ Employer____
Policy #__________________ Group #______________ Policy #_________________ Group #_______________
Policy Holder Sex: Male / Female Policy Holder Sex: Male / Female
Policy Holder Birth Date____________________________ Policy Holder Birth Date_____________________________

Do you have an Advance Directive/Living Will? YES / NO
Do you have a Power of Attorney? YES / NO
Do you need us to provide you with the Power of Attorney documentation? YES / NO

IF YOU HAVE A POWER OF ATTORNEY AND/OR LIVING WILL PLEASE PROVIDE A COPY TO US FOR YOUR RECORDS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Sylvain Sidi, MD, FACG to release medical information requested by insurance companies or any public agency which may be assisting in payment of the above patient's medical care.

AUTHORIZATION OF INSURANCE BENEFITS: I authorize payment of benefits to be paid to Sylvain Sidi, MD, FACG. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits when coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including attorney fees.

REFERRALS: I understand that obtaining a referral is my responsibility. If I am seen without the necessary authorization and/or referral, I understand that I am liable for all charges.

This release of medical information is an assignment of benefits and is considered in force from the date of signing until revoked in writing.

____ ________________________________

(Patient or Responsible Party's Signature Date

FINANCIAL POLICY

Payment is due at the time services are rendered. We accept cash, checks, and major credit cards. If you have medical insurance, we will be happy to help you process your insurance claim form. However, you will still be responsible for any deductible/co-pay at the time services are rendered.

A finance charge will be assessed on all accounts 60 days from the date services are rendered. The finance charge is computed at the rate of 1.5% per month; and annual percentage rate of 18%.

A charge of $25.00 may also be made for returned checks, broken appointments, and appointments or procedures cancelled without 72 hours advance notice.

As previously stated, if you have medical insurance, we are anxious to help you receive your maximum benefits. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Without general exception, our fees fall within the "Usual, Reasonable, and Customary" ranges determined by each insurance carrier for this region. This applies only to companies who pay a percentage of the fee (such as 50% or 80%). This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which is not based on fees appropriate to the current standard of care in this area.
3. Not all services are covered benefits: some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. With my signature below, I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I also authorize Dr. Sidi to initiate a complaint to the insurance commissioner for any reason on my behalf.

We realize that in rare instance, temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us for assistance in the management of your account. If you have any questions about the above information, or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us.

I have read the financial policy above. I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account and payment of fees. A photocopy of this Assignment shall be considered as effective and valid as the original.

____________________________________ ______________________________

Signature (Parent if Minor) Date

OFFICE POLICY

When scheduling appointments, it is our intent to see you as soon as possible. Our staff and physician will make every effort to accommodate urgent add on requests. Please be aware that due to the nature of our practice, emergencies are common and may cause delays. We allow 15 minutes prior to your appointment to complete the registration process. We will make every effort to see you on time at your scheduled visit. Individuals arriving early for their appointments may not be taken until the scheduled time to avoid delaying other patients unnecessarily. For your appointment, please bring with you all medical reports, x-rays, scans, etc. that need the doctor's review during your consultation. Patients are expected to bring these upon arrival to the office the day of the appointment. Due to experiences with these items getting delayed if sent through the mail, we prefer the patient obtain these materials and bring them the day of their appointment.

Cancellations: We reserve your appointment exclusively for you. If you cannot keep your appointment, please give us at least 24 business hours notice. (This does not include leaving a message with the answering service.) If you will be unavoidably late for your appointment, please call us to let us know. If you arrive very late, we may need to reschedule your appointment. ***There will be a charge for "no-shows" or missing your appointment equal to your specialist office visit co-pay.***

Prescription Refills: We will provide a refill on a one time basis. We ask that you provide at least 72 hours notice. Please call the pharmacy and request them to fax our office for authorization on the refill. This will facilitate your request in a timely manner. The clinical staff will submit your request to Dr. Sidi. Once the refill has been authorized, it will be called or faxed to your pharmacy. **FOR ADDITIONAL REFILLS**, please contact your primary physician.

Procedure/Test Results: You will receive a letter in the mail 10 business days following your procedure informing you of the results. If Dr. Sidi wants to see you in consult to discuss your results, you will be contacted by a clinical staff member by phone to schedule an appointment.

After Hours Calls: Please limit after-hour calls to urgent and emergency needs. If you have an urgent medical situation, call (520)884-1994 to reach our answering service. They will contact the doctor immediately, who will return your call as soon as possible. **DO NOT CALL THE SERVICE TO CANCEL OR CHANGE APPOINTMENTS.** If an unforeseen circumstance comes up regarding your appointment, please call the office at 8:00am.

Patient Initials__________________ Date________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SYLVAIN SIDI, MD, FACG
310 N WILMOT RD, SUITE 202 TUCSON, AZ 85711 (520)885-7600 PHONE (520)885-7601 FAX

I, ______________________________, authorize Dr. Sylvain Sidi's office to release information and/or results as follows:

__1. The office may leave a message on my answering machine/voicemail. (Only negative/normal results will be left in a message.)
__2. The office may release information to myself only.
__3. The office may release my information to __________________________________.
Name of Authorized Individual/Relationship

____________________________________ ________________________
Signature of Patient Date

Printed Patient Name_________________________________

Address of Patient____________________________________
____
____

Patient Telephone # ___________________________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SYLVAIN SIDI, MD, FACG
310 N WILMOT RD, SUITE 202 TUCSON, AZ 85711 (520)885-7600 PHONE (520)885-7601 FAX

SYLVAIN SIDI, MD, FACG

I hereby request that my medical records be released **TO:**
Sylvain Sidi, M.D., FACG
310 N Wilmot Rd, Suite 202
Tucson, AZ 85711
Phone: (520)885-7600
Fax: (520)885-7601

Today's Date____________________

Patient's Printed Name__________________________________

Date of Birth_____________________

Patient Signature_______________________________________

Records to be released from:____
____

Phone Number______________________
Fax Number_________________________

INTEROFFICE USE ONLY:
Initials of staff member completing records request______________
Date request was submitted_______________

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient, records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____ date________________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

IMPORTANT NOTICE FOR NO SHOW APPOINTMENTS

To Our Valued Patients:

In our dedicated efforts to assist you with your medical needs, please note the following:

Giving undivided attention to each and every one of our patients is very important to us. We therefore block out time for your scheduled visit accordingly.

Office Appointments:
In the event that you need to cancel or reschedule your office appointment, PLEASE NOTIFY OUR OFFICE AT LEAST 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TIME. Failure to provide adequate notice will result in being considered a “no-show.”

Please be advised you are allowed a total of three no show appointments and a fee of $50.00 may be charged for each one. After the third no show, you may be asked to seek medical care elsewhere.

Procedures:
If you need to cancel or reschedule your procedure, PLEASE NOTIFY OUR OFFICE AT LEAST 8 DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT TIME. Failure to provide adequate notice will result in being considered a “no-show.” Please be advised that a fee of $100.00 may be charged.

We appreciate your cooperation and look forward to continuing caring for you and your family.

Patient Name (printed)______________________________ Date of Birth_____________________

Patient Signature___________________________________ Date of Birth_____________________

Parent or Guardian Signature________________________ Date of Birth_____________________
(if indicated)