



Treasure Valley Gastroenterology Specialists

Raquel Croitoru, M.D.

Board Certified Gastroenterology
Fellow American College of Gastroenterology

PATIENT INFORMATION

Date Completed: _____

Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

SS#: _____ Driver License #: _____ State: _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

Spouse or Responsible Party: _____

Date of Birth: _____ SS#: _____ Employer: _____

Work Phone: _____ Cell Phone: _____

In Emergency Please Notify: _____

Address: _____ Phone: _____

Work Phone: _____ Cell Phone: _____

Primary Care Doctor: _____ Phone: _____

Fax: _____

AS A COURTESY we will bill your primary and secondary insurance carrier if you provide **ALL** necessary information (such as insurance cards and/or completed and signed claim forms if your carrier requires it and their **CORRECT** billing address). Co-pays and share of cost are collected for each visit. **A \$35.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.**

SIGNATURE OF PATIENT OR GUARDIAN: _____

FOR BILLING PURPOSES WE REQUIRE THIS FORM TO BE FULLY COMPLETED. WE RESERVE THE RIGHT TO RESCHEDULE ANY APPOINTMENTS DUE TO INCOMPLETE FORMS OR TARDINESS. THANK YOU FOR YOUR COOPERATION. IF ANY INFORMATION CHANGES A NEW FORM MUST BE COMPLETED.

INFORMATION VERIFIED (DATE / INITIALS)



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Patient:

DOB:

DOS:

REVIEW OF SYSTEMS

Please indicate, on all items, if you have experienced the symptom now, in the last three months, or not at all:

Form with columns for YES NOW, LAST 3 MO, NO and various system categories: GENERAL, RESPIRATORY, ENDOCRINE/HEMATOLOGICAL, MUSCULOSKELETAL, VISION, CARDIOVASCULAR, GENITOURINARY, SKIN, EAR/NOSE/THROAT, NERVOUS SYSTEM, WOMEN ONLY.

Patient: _____ DOB: _____ DOS: _____

REVIEW OF SYSTEMS (CONT)

YES NOW	LAST 3 MO	NO	GASTROINTESTINAL
Y	Y	Y	Nausea
Y	Y	Y	Vomiting / What Comes Up _____
Y	Y	Y	Difficulty Swallowing
Y	Y	Y	Food Sticks In Throat
Y	Y	Y	Pills Sticks In Throat
Y	Y	Y	Food Coming Up to Throat
Y	Y	Y	Burning In Chest
Y	Y	Y	Burning In Stomach
Y	Y	Y	Ever Had Ulcers / When _____
Y	Y	Y	Decrease In Appetite
Y	Y	Y	Pain When Eating
Y	Y	Y	Filling Full Easily When Eating
Y	Y	Y	Red Rectal Bleeding
Y	Y	Y	Black Stools
Y	Y	Y	Liver Disease / When _____
Y	Y	Y	Diarrhea
Y	Y	Y	Constipation
Y	Y	Y	Use Laxatives At Least Once A Week / How Often _____
Y	Y	Y	Change In Bowels
Y	Y	Y	Can't Control Bowels
Y	Y	Y	Abdominal Pain / Where _____
Y	Y	Y	Bloating / Gas
Y	Y	Y	Food Intolerances / What _____

Please list any other symptoms that you think may be important:



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Patient: _____ DOB: _____ DOS: _____

MEDICAL HISTORY

Have we seen you before: YES / NO When: _____

Have we seen a family member: YES / NO Name: _____

Please describe in your own words why you are being seen: _____

PLEASE BRING A COPY OF ALL YOUR CURRENT MEDICATIONS, INCLUDING ANY OVER THE COUNTER MEDICINES, VITAMINS, OR HERBAL SUPPLEMENTS. (NAME, DOSE, TIMES A DAY)

PAST MEDICAL HISTORY - PLEASE CHECK IF YOU HAVE HAD ANY OF THESE

- Checklist of medical conditions including Rheumatic Fever, Angina Pectoris, Heart Valve Replaced, Iron Deficiency, Kidney Disease, Lactose Intolerance, Diabetes, Hypertension, etc.

List any other significant illness (exclude typical childhood) _____

List all surgeries (type & year) _____

List all serious injuries/accidents (type & year) _____

List all hospitalizations not included above (reasons & year) _____

List all allergies to medications (name & reaction) _____

Patient: _____ DOB: _____ DOS: _____

MEDICAL HISTORY (CONT)

List any other allergies (food, tape, iodine, etc.) _____

PERSONAL HABITS

Occupation: _____

Marital Status: Married / Divorced / Single / Widow / Live With Partner

Do you use tobacco: YES / NO Type: _____ Amnt Daily: _____ # of Years: _____

 Did you use before: YES / NO Type: _____ Amnt Daily: _____ Quit Year: _____

Do you drink alcohol: YES / NO Type: _____ Amnt Daily: _____ # of Years: _____

 Did you drink before: YES / NO Type: _____ Amnt Daily: _____ Quit Year: _____

Do you use illegal drugs: YES / NO Type: _____ Amnt Daily: _____ # of Years: _____

 Did you use before: YES / NO Type: _____ Amnt Daily: _____ Quit Year: _____

Do you drink caffeine: YES / NO Type: _____ Amnt Daily: _____ # of Years: _____

 Did you drink before: YES / NO Type: _____ Amnt Daily: _____ Quit Year: _____

Do you think you may be pregnant: YES / NO Have you felt like a victim of abuse: YES / NO

Have you ever worried that someone may hurt you: YES / NO If Yes was/is it: PRIOR / NOW

Been tested for hepatitis: YES / NO Been vaccinated for hepatitis A or B: YES / NO When _____

Been tested for HIV/AIDS: YES / NO Have you had a blood transfusion: YES / NO When: _____

List any other aspects of your life that may affect your health: _____

FAMILY MEDICAL HISTORY – CHECK IF ANY BLOOD RELATIVE HAS HAD THE FOLLOWING AND LIST WHO

- | | | | |
|-------------------------|-----------------------------|---------------------------|--------------------|
| ÿ Colitis _____ | ÿ Liver Disease _____ | ÿ Anemia _____ | ÿ Cancer _____ |
| ÿ Colon Polyps _____ | ÿ Cirrhosis _____ | ÿ Bleeding Disorder _____ | ÿ Colon _____ |
| ÿ Pancreatitis _____ | ÿ Gall Bladder Stones _____ | ÿ Kidney Disease _____ | ÿ Breast _____ |
| ÿ Ulcers _____ | ÿ Crohn's Disease _____ | ÿ Depression _____ | ÿ Uterine _____ |
| ÿ Diabetes _____ | ÿ Wilsons Disease _____ | ÿ Hypertension _____ | ÿ Thyroid _____ |
| ÿ Thyroid Disease _____ | ÿ Hemochromatosis _____ | | ÿ Pancreatic _____ |

	If Living		If Deceased	
	Age	Health	Age	Cause
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brother(s)				
Brother(s)				
Sister(s)				
Sister(s)				
Son(s)				
Son(s)				
Daughter(s)				
Daughter(s)				



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HIPAA CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
 - Obtain payment from third-party payers.
 - Conduct normal healthcare operations such as quality assessments and physician certifications.
-
- I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.
 - I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
 - I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.
 - I have read/received a copy of the Patient's Bill of Rights & Responsibilities.

Patient Name: _____

Signature: _____

Relationship To Patient: _____

Date: _____



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PATIENT AUTHORIZATION SIGNATURE FORM

Patient Name: _____ **Date:** _____

Treasure Valley Gastroenterology requires this form to be signed by our patients. We appreciate your cooperation. **If you have ANY questions, please ask the receptionist.**

3 **FINANCIAL RESPONSIBILITY:** *I understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with Treasure Valley Gastroenterology. I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance to Treasure Valley Gastroenterology.*

Ø *Exceptions to this policy are those patients with a current authorization with an HMO, a State or Federally funded program, or a PPO in which Treasure Valley Gastroenterology is currently a contracted provider.*

3 **AUTHORIZATION TO RELEASE INFORMATION:** *I HEREBY AUTHORIZE Treasure Valley Gastroenterology to release medical information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care.*

3 **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** *I hereby authorize the payment for medical services provided directly to Treasure Valley Gastroenterology and Raquel Croitoru, MD.*

3 **PLEASE READ AND THEN CHOOSE YES or NO:** *If you are unavailable, may we leave medical information, such as normal blood test results or normal biopsy reports on your answering machine or with someone at your residence?*

§ _____ **YES ~ you may leave information as above.**

§ _____ **NO ~ Do not leave any information with anyone.**

3 **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY:** *I acknowledge that I have received a copy of Treasure Valley Gastroenterology's privacy Policy.*

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

By signing you agree to all the above terms and conditions.



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PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE

Your signature below forms a binding agreement between Treasure Valley Gastroenterology (TVG – the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

As a courtesy, we will bill your primary and secondary insurance carrier if you provide **ALL** necessary information (such as insurance cards and/or completed and signed claim forms if your carrier requires it, and their **CORRECT** billing address.) ALL co-pays are collected for each visit at check-in.

MEDICAL INSURANCE: We are contracted with Medicare, Medicaid, Blue Cross and Blue Shield, and we will bill them as a service (courtesy) to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. Your coverage is a contract between YOU and YOUR INSURANCE COMPANY. Should they fail to make payment on a claim for any reason, you are responsible for the remaining balance.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform TVG of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current.
- Pay any required co-pay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. *(When TVG receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

Returned Check Policy: If a payment is made on an account by check and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a \$35.00 Service Charge. Once notice is received of the returned check, TVG will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee of 50% will be added to the outstanding balance – in addition to the \$35.00 Check Service Charge.

Non-Payment on Account: Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that TVG has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee of 50% will be added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Responsible Party: _____

Signature: _____ **Date:** _____



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**PATIENT RECORDS REQUEST and
AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Healthcare Provider: _____

Address: _____

I hereby authorize the release of medical information on:

Patient: _____ Date of Birth: _____

MEDICAL INFORMATION REQUESTED

<u>Time Frame</u>
<input type="checkbox"/> Most Recent Only
<input type="checkbox"/> Last (3) Three Months
<input type="checkbox"/> Last (1) One Year
<input type="checkbox"/> Last (2) Two Years
<input type="checkbox"/> Specific Date _____
<input type="checkbox"/> Other _____

<u>Items To Be Released</u>
<input type="checkbox"/> All medical Records
<input type="checkbox"/> Allergy Records
<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> H & P
<input type="checkbox"/> Laboratory Data
<input type="checkbox"/> Medication Lists
<input type="checkbox"/> Operative Reports
<input type="checkbox"/> X-Ray Reports
<input type="checkbox"/> Other _____

To provide the best possible medical care to the patient I hereby consent to the release of the medical information specified above. Please send the requested medical records to:

Raquel Croitoru, MD
Treasure Valley Gastroenterology
222 W. Iowa Ave. Suite A
Nampa, ID 83686
Phone: 208-467-3432 • Fax: 208-467-4147

Signature: _____ Date: _____

Relationship To Patient: _____



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PROTECTED HEALTH INFORMATION RELEASE (PHI)

Patient Name: _____ Date of Birth: _____

Please check all that apply:

You have my permission to speak with my spouse about my medical care. (list below)

You have my permission to leave information on my answering voice mail/answering machine regarding my medical care and test results.

You have my permission to talk with my children or other family members involved with my medical care. (list below)

You have my permission to call me at work.

AUTHORIZED INDIVIDUALS

(People who can be informed about my health care)

Name: _____ Relationship: _____

Home Phone: _____ Cell/Other Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell/Other Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell/Other Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell/Other Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell/Other Phone: _____

Other, Please Describe: _____

Patient Signature

Date