Treasure Valley Gastroenterology Specialists
Raquel Croitoru, M.D.
Board Certified Gastroenterology
Fellow American College of Gastroenterology

WELCOME to TREASURE VALLEY GASTROENTEROLOGY, where we provide quality health care in a compassionate and caring way. You have been scheduled for an office appointment with us. If you have any questions about these forms or your procedure please call our offices at (208) 467-4147.

On _____ at _____AM/PM
this is your arrival time, you do not have to come in earlier.

Please find in your packet the following items. Please read each of them carefully and fill out all forms fully. Anything not completed will need to be completed prior to your admittance.

VV	ITEM
	Patient Information
	Review of Systems
	Medical History
	Records Request Release
	Patient Health Information Release
	Patient Financial Responsibility
	Patient Authorization
	Preparation Instructions

Also please bring these items from home:

VV	ITEM
	Co-Pay/Deductable Payment
	Insurance Cards
	Photo Identification
	Bottles or Written list of current medications and supplements to include dose and when taken. (include prescriptions, over-the-counter meds vitamins and minerals)

In the event that you must cancel your appointment, kindly notify our office at least 24 hours in advance. Failure to notify the office may result in the assessment of a fee. Our entire staff is here to help meet your needs while providing excellence in the diagnosis and treatment of your digestive system. Please feel free to ask us any questions you have either before, during or after your visit.

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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:

YES NOW	LAST 3 MO	NO	GENERAL
Ä	Ä	Ä	Feel Tired / Worn Out
Ä	Ä	Ä	Feel Too Hot / Cold
Ä	Ä	Ä	Chill / Fever / Sweats
Ä	Ä	Ä	Feel Depressed
Ä	Ä	Ä	Weight Gain Lbs _____
Ä	Ä	Ä	Weight Loss Lbs _____

NOW	3 MO	NO	ENDOCRINE/HEMATOLOGICAL
Ä	Ä	Ä	Swollen Glands
Ä	Ä	Ä	Been Anemic
Ä	Ä	Ä	Bleed For Prolonged Time Periods
Ä	Ä	Ä	Bruise Easily

NOW	3 MO	NO	VISION
Ä	Ä	Ä	Sensitivity To Light
Ä	Ä	Ä	Pain In Your Eyes
Ä	Ä	Ä	Blurry Vision
Ä	Ä	Ä	Change In Vision
Ä	Ä	Ä	Glaucoma

NOW	3 MO	NO	GENITOURINARY
Ä	Ä	Ä	Burning / Painful Urination
Ä	Ä	Ä	Frequent Urination
Ä	Ä	Ä	Difficulty Urinating
Ä	Ä	Ä	Blood In The Urine
Ä	Ä	Ä	Incontinence (Urine Leakage)
Ä	Ä	Ä	Brown/Coke Colored Urine
Ä	Ä	Ä	I Think/Have A Urinary Infection

NOW	3 MO	NO	EAR/NOSE/THROAT
Ä	Ä	Ä	Trouble Hearing
Ä	Ä	Ä	Ear Pain
Ä	Ä	Ä	Stuffy Nose
Ä	Ä	Ä	Sinus Pain
Ä	Ä	Ä	Lump In Throat
Ä	Ä	Ä	Sore Tongue / Mouth
Ä	Ä	Ä	Burning In Throat
Ä	Ä	Ä	Hoarseness
Ä	Ä	Ä	Nose Bleeds
Ä	Ä	Ä	Mouth Sores/Ulcers

YES NOW	LAST 3 MO	NO	RESPIRATORY
Ä	Ä	Ä	Cough
Ä	Ä	Ä	Difficulty Breathing – At Rest
Ä	Ä	Ä	Difficulty Breathing – W/Exertion
Ä	Ä	Ä	Difficulty Breathing – Lying Down
Ä	Ä	Ä	Shortness Of Breath
Ä	Ä	Ä	Wheezing

NOW	3 MO	NO	MUSCULOSKELETAL
Ä	Ä	Ä	Pain / Ache In Muscles
Ä	Ä	Ä	Pain / Ache In Joints
Ä	Ä	Ä	Difficulty Walking
Ä	Ä	Ä	Swelling In Joints

NOW	3 MO	NO	CARDIOVASCULAR
Ä	Ä	Ä	Pain / Pressure In Chest – At Rest
Ä	Ä	Ä	Pain / Pressure In Chest – W/Activity
Ä	Ä	Ä	Swelling In Feet / Ankles
Ä	Ä	Ä	Irregular Heart Beat
Ä	Ä	Ä	Altered Heart Beat: Fast? Slow? (Circle One)

NOW	3 MO	NO	SKIN
Ä	Ä	Ä	Skin Rashes / Itching
Ä	Ä	Ä	Changes In Hair / Nails
Ä	Ä	Ä	Skin Changed Color
Ä	Ä	Ä	Dry Skin
Ä	Ä	Ä	Open Sores
Ä	Ä	Ä	Skin Infections w/MRSA

NOW	3 MO	NO	NERVOUS SYSTEM
Ä	Ä	Ä	Frequent Headaches
Ä	Ä	Ä	Memory Loss
Ä	Ä	Ä	Poor Balance
Ä	Ä	Ä	Tingling In Arms / Legs
Ä	Ä	Ä	Dizziness / Fainting
Ä	Ä	Ä	Seizures
Ä	Ä	Ä	Tremors/Repetitive Movements
Ä	Ä	Ä	Weakness In Legs

NOW	3 MO	NO	WOMEN ONLY
Ä	Ä	Ä	Abnormal Menstrual Periods
Ä	Ä	Ä	Lumps In Breasts
Ä	Ä	Ä	Passed Menopause
Ä	Ä	Ä	Nipple Discharge
Ä	Ä	Ä	Pregnant (let us know if this changes)

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Patient: _____ **DOB:** _____ **DOS:** _____

REVIEW OF SYSTEMS (CONT)

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

Ä Rheumatic Fever	Ä Iron Deficiency	Ä Lactose Intolerance
Ä Angina Pectoris	Ä Kidney Disease	Ä Diabetes
Ä Heart Valve Replaced	Ä Kidney Stones	Ä Hyperglycemic
Mechanical Y / N	Ä Ulcers	Ä Migraines
Ä Defibrillator Implant	Ä Colitis	Ä Glaucoma
Ä Heart Rhythm Problem	Ä Irritable Bowl Syndrome (IBS)	Ä Cataracts
Ä Aortic Stenosis	Ä Arthritis – Rheumatoid	Ä Thyroid Disorder Low/Hypo -or Hi/Hyper
Ä Mitral Valve Prolapse	Ä Arthritis - Osteo	Ä Gout
Ä Other Valve Problem_____	Ä Seizures / Epilepsy	Ä Cancer, Type: _____
Ä Heart Attack	Ä Stroke / TIA	Ä Liver Disease / Jaundice
Ä Vascular Graft/When_____	Ä B-12 Deficiency	Ä Hepatitis A / B / C
Ä Cardiac Stent/When_____	Ä Esophageal Problems	Ä Immune Deficiency
Ä Other Heart Disease	Ä Crohn's Disease	Ä Depression
Ä High Blood Pressure	Ä Emphysema	Ä Sleep Apnea
Ä Anemia	Ä Frequent Lung Infections	Ä Anxiety
Ä Prophyria	Ä Asthma	Ä Anorexia/Bulimia
Ä Prolonged Bleeding	Ä Tuberculosis	Ä Osteoporosis
Ä Blood Disease	Ä Gluten Allergy/Coeliac Disease	Ä Osteopenia
Ä B-12 Deficiency	Ä Glucose G6PD Deficiency	

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) _____

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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

Ä Colitis _____ Ä Liver Disease_____ Ä Anemia_____ Ä Cancer_____

Ä Colon Polyps _____ Ä Cirrhosis_____ Ä Bleeding Disorder_____ Ä Colon_____

Ä Pancreatitis_____ Ä Gall Bladder Stones_____ Ä Kidney Disease_____ Ä Breast_____

Ä Ulcers _____ Ä Crohn's Disease _____ Ä Depression_____ Ä Uterine_____

Ä Diabetes _____ Ä Wilsons Disease _____ Ä Hypertension_____ Ä Thyroid_____

Ä Thyroid Disease_____ Ä Hemochromatosis _____ Ä 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.**

× **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.*

- ü *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.*

× **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.*

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

× **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?

- Á _____ ***YES ~ you may leave information as above.***
- Á _____ ***NO* ~ Do not leave any information with anyone.**

× **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

Time Frame

- Ä Most Recent Only
- Ä Last (3) Three Months
- Ä Last (1) One Year
- Ä Last (2) Two Years
- Ä Specific Date _____
- Ä Other_____

Items To Be Released

- Ä All medical Records
- Ä Allergy Records
- Ä Discharge Summary
- Ä H & P
- Ä Laboratory Data
- Ä Medication Lists
- Ä Operative Reports
- Ä X-Ray Reports
- Ä Other _____

To provide the best possible medical care to the patient I herby 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