Western Washington Medical Group
Gastroenterology

Dear New Patient:

APPOINTMENT SCHEDULED: CHECK IN TIME:

WITH DOCTOR: PHONE: **425-259-3122 (for all offices)**

EVERETT OFFICE
43rd & Hoyt Medical Bldg.
4225 Hoyt Ave, Suite A
Everett

MONROE OFFICE
Evergreen Health Services
14701 – 179th SE, Monroe
(Main hospital entrance 2nd floor)

ANACORTES
Island Hospital
Center for Aesthetic Service
2511 M Avenue, Ste C
Anacortes

FRIDAY HARBOR
Peace Island Med Ctr
1117 Spring St
Friday Harbor

ENDOSCOPY CENTER
Providence Regional Mill Creek
12800 Bothell – Everett Hwy. # 200
(also known as 19th Ave SE or Hwy 527)
Everett

WHIDBEY ISLAND OFFICE
Whidbey Community Physicians
275 SE Cabot Dr. #101
Oak Harbor WA

WOODLANDS OFFICE
Woodlands Technology Bldg
1909 -214th St. SE # 211
Bothell (Canyon Park)

In an effort to make you more at ease on your first visit to our office, we have enclosed a packet of information and forms for you to read, fill out at your leisure at home, and **bring with you to your appointment.** Here is a checklist of the forms that are enclosed and short explanation of each:

- Registration Form – please remember to also bring **all of your insurance cards**. We will need to scan a copy of the front and the back of the actual card(s). If **your insurance plan requires a copayment** we will collect it at the time of your visit. If your **insurance plan requires a referral** it is your responsibility to obtain one from your primary care physician, prior to this office visit. If you have difficulty obtaining the referral from your PCP please call our referral coordinator at (425) 259-3122, to see if she can assist you in any way.
- The Financial Policy – this is your acknowledgement that you understand our billing procedures for submitting your claims to your insurance company. It is also a reminder that ultimately you are the responsible party. Please be assured that we will do everything that we can to make sure that your insurance pays your claims, if it is within your policy limits.
- Friends and Family Release - List the family members, friends, or caregivers that you wish to have access to your private healthcare information. We are required by law to have your signature on this verbal disclosure form.
- Medical History Form – it is extremely important to complete the form as fully as possible. This will enable us to care for you appropriately. If you require additional room, please write on a plain sheet of white paper and attach it to the History Form.
- Medications Form – please fill out this form for all the medications that you are currently taking. Please include all information about these medications such as the dosage and how often you take them. You should also include information about any herbal or over the counter medications, vitamins, minerals etc. that you take on a regular basis.
- Information Pamphlet – this tells you about our providers.
- General Information – this tells you more about our office policies and procedures.
- Directions and map to the office which is highlighted above. We regularly see patients at many different locations. Please be sure that you note the correct office location for your appointment.

It is our hope that you will find this material informative, and that by completing these forms in advance of your appointment your time in our office will be better spent. Again, thank you for taking the time to have all of your forms ready when you arrive for your appointment. We look forward to participating in your medical care.

WESTERN WASHINGTON MEDICAL GROUP ***REGISTRATION FORM***

ACCOUNT#_____ **NEW** _____ **UPDATE** _____

PATIENT LAST NAME	**FIRST NAME (legal)**	**MI**	**PREFERRED OR NICKNAME**	**DATE OF BIRTH**

RACE	**ETHNICITY**	**PREFERRED LANGUAGE**	**SOCIAL SECURITY #**

SEX M ___ F ___ Other: _____ (Please List)	**GENDER IDENTITY:** __Genderqueer identifies as neither Male or Female __Identifies as Male __Female-to-male __Additional gender category or other, please specify _____ __Identifies as Female __Male-to-female __Choose not to disclose	**SEXUAL ORIENTATION** __ Choose not to disclose __ Heterosexual (straight) __ Bisexual __ Homosexual (gay/lesbian) __ Other _____

MAILING ADDRESS	**APT #**	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**
STREET ADDRESS	**APT #**	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**

HOME PHONE	**WORK PHONE** **EXT**	**CELL PHONE**	**PREFERRED EMAIL ADDRESS**
( )	( )	( )	

REFERRING DOCTOR	**HOW DID YOU HEAR OF US?**	**MARITAL STATUS**
	Internet ___ Google Maps ___	MARRIED _____ DIVORCED _____ OTHER _____
PRIMARY CARE DOCTOR	Friend/Family ___ Drove by location ___ Insurance Company ___ Mailer/ Marketing ___	SINGLE _____ WIDOWED _____ SEPARATED _____

PHARMACY NAME, PHONE NUMBER AND LOCATION

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU: RETIRED_____ OR DISABLED_____?)

EMPLOYER NAME	**OCCUPATION**

STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**

PRIMARY INSURANCE

INSURANCE COMPANY NAME	**RELATION TO SUBSCRIBER**	**COPAY**
SUBSCRIBER'S NAME	**SUBSCRIBERS EMPLOYER**	

SUBSCRIBERS DATE OF BIRTH	**SUBSCRIBER'S SEX**	**SUBSCRIBERS ID #**	**GROUP NUMBER**
	MALE ___ FEMALE ___ OTHER ____		

SECONDARY INSURANCE

INSURANCE COMPANY NAME	**RELATION TO SUBSCRIBER**	**COPAY**
SUBSCRIBER'S NAME	**SUBSCRIBERS EMPLOYER**	

SUBSCRIBER'S DATE OF BIRTH	**SUBSCRIBERS SEX**	**SUBSCRIBERS ID #**	**GROUP NUMBER**
	MALE ___ FEMALE ___ OTHER ____		

EMERGENCY CONTACT

(NOT LIVING WITH YOU)	**NAME**	**RELATIONSHIP**	**PHONE NUMBER- HOME/WORK/CELL** ( )

RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

_____ **SELF** (* If self do not fill in right field.) _____ **SPOUSE** _____ **PARENT** _____ **GUARDIAN**	**SOCIAL SECURITY #**	**LAST NAME**	**FIRST NAME**	**MI**
	STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**
	HOME PHONE ( )	**WORK OR CELL PHONE** **EXT** ( )	**DATE OF BIRTH**	**SEX** M __ F __ Other __

WORKERS COMP CLAIM #	**DATE OF INJURY**	**EMPLOYER**	**STATE OR SELF INSURED?**

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize **Western Washington Medical Group** to leave messages, which may contain details of my medical condition on my voicemail box if they are unable to reach me.

INITIALS VOICEMAIL #

PATIENT SIGNATURE ***DATE***

For office use only

Dr._____ **Ins. code**_____ **Acct #**_____ **Initials**

Western Washington Medical Group
Gastroenterology

2014 FRIENDS AND FAMILY RELEASE

The name(s) listed below are family members or friends to whom I wish to grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary and appropriate. I understand that information is limited to verbal discussions and that **no paper copies of my Personal Healthcare Information (PHI) will be provided without my signature** to release information from my chart. I, the patient, may be asked to sign a Release of Record to release WWMG to share information if my provider and his/her designee deem it necessary.

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Patient's Personal Phone Information : NOTE! This is DIFFERENT than the above info.

Please provide us with **YOUR *best, most current*** phone contact information. This information will become part of your permanent medical record *unless/until you change it*. You can change this information simply by asking to complete a new form.

Please note: by approving the option to leave a detailed message you are allowing us to leave sensitive health information and specifics related to referrals.

First phone number: _____ Cell Work Home OK to leave detailed message: Y N

Second phone number: _____ Cell Work Home OK to leave detailed message: Y N

Third phone number: _____ Cell Work Home OK to leave detailed message: Y N

X _____ _____
PATIENT OR GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

X _____ _____
PRINTED name of person signing DATE

Western Washington Medical Group
Gastroenterology

FINANCIAL AGREEMENT

We consider all patients as "private" unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for "private" patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance; it is the patient's responsibility to check their benefits prior to being seen.

- Please be familiar with the benefits provided by your health plan.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is YOUR responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Co-pays are due at time of service, if you are unable to pay your co-pay at time of service there will be an additional **$15.00 fee** charged to your account.

A No-show fee for procedures of $250.00 will be charged if not cancelled a minimum of 5 business days prior to the procedure.

Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for payments of interest on the unpaid balance of 1% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

We charge **$35.00** for any NSF checks (per RCW 62A-3-515 & 520)

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the physician to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my physician.

I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Printed Name_____ DOB _____

Signature_____Date_____

Western Washington Medical Group
Gastroenterology

Office Appointment Late Cancellation and No Show Policies

Late cancellations or no-shows cause unnecessary longer wait time for patients who need to be seen in the office. In order to provide quality medical care in a timely manner, we have to implement a no show/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

To cancel and/or reschedule an office appointment, patients must call 425-259-3122 during business hours (Monday through Friday 8:30am to 5:00pm, closed 12:00pm to 1:00pm for lunch).

Advance cancellations: If an office appointment is canceled or rescheduled ***48 hours before*** the scheduled time, it is considered an advance cancellation and there will be no cancellation or reschedule fees.

Late cancellations: If an office appointment is canceled or rescheduled ***within 48 hours of*** the scheduled time, it is considered a late cancellation. The patient will be charged a late cancellation fee of $50.

No Show: if patient fails to present at the time of a scheduled appointment without any prior notice, it is considered a "no show". The patient will be charged a "no show" fee of $100.

Insurance companies will not be billed for this fee, which is the sole responsibility of the patient. However the patient will not be charged if there was a true medical emergency and the patient was in the ER or hospitalized at the time of scheduled appointment.

Payment schedule: From the date of the no-show or late cancellation the patient has 60 days to make the payment for the no-show or late cancellation fee.

- During the 60 days before payment is made by the patient, the patient must make a $100.00 deposit to reschedule a non-emergent office appointment. The deposit will not be refunded if the patient has another late cancellation or no show. We will continue to provide emergency gastroenterology care and prescription renewals for 60 days without a deposit.
- At the end of the 60 days, if the payment is still not received, a termination of care letter will be sent to the patient advising the patient of discharge from practice. Emergency gastroenterology care will be provided for an addition 30 days from the date of discharge letter.

Revised 7/8/15

- The patient may be admitted back to the practice if the fee is paid after the 60-day "grace period". However the patient must make a $100 deposit for the first office appointment (this requirement is only for those who did not pay fees within 60 days and was discharged). If the patient cannot afford to or unwilling to make the deposit, the patient cannot be admitted back to the practice.

Each patient will be tracked for the number of no shows and late cancellations. If the number of either or the combination of late cancellations and no-shows exceed three (3) occurrences within any consecutive 12 months, the patient will be discharged from the practice and no further appointments will be scheduled.

Signature _____ *Date* _____

*Print Name*_____ *DOB:*_____

Revised 7/8/15

Western Washington Medical Group
Endoscopy Center

Endoscopy Procedure Late Cancellation and No Show Policies

A late cancellation or "no show" is someone who misses a procedure appointment without canceling it **5 business days in advance** or someone who fails to present at the time of a scheduled procedure without notice. ***The patient will be charged $250.00 for either late cancellations or no shows. The procedure cannot be re-scheduled until the $250.00 charge is paid by the patient.*** Insurance companies will not be billed for this fee.

This agreement applies to endoscopy procedures performed by our providers at WWMG Endoscopy Center, Providence Medical Center, Evergreen Health Monroe, Whidbey General Hospital, and/or Island Hospital.

By my signature, I certify that I have read and understand the policy.

Signature _____ Date _____

Print Name _____ DOB: _____

Revised 7/8/15

DATE _____

PATIENT NAME: _____ DATE OF BIRTH _____

PHARMACY NAME _____ PHARMACY PHONE # _____

LOCATION _____ PHARMACY FAX # _____

****Please list all medications including** over the counter medications, vitamins antacids, herbal preparations *that you are currently taking.*

Aspirin ☐ Ibuprofen/Advil/Aleve ☐ Arthritis medication ☐

DATE STARTED	NAME OF MEDICATION, DOSE	# of times per day	PRESCRIBED BY
	EXAMPLE		
9/10/2009	NEXIUM 40 MG	1 x per day	Dr. XYZ

Western Washington Medical Group
Gastroenterology

PLEASE USE BLACK INK ONLY

Please Print

MEDICAL QUESTIONNAIRE

Name _____ Date of Birth _____ Age: _____

Referring physician: _____ Primary care physician: _____

Why are you here? _____

What makes the problem better or worse? What medication have you tried?

_____

GI Review of Systems: *CHECK ANY OF THE FOLLOWING YOU HAVE HAD, IF IN DOUBT PUT A QUESTION MARK*

- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Food sticking
- ☐ Heartburn
- ☐ Hiatal Hernia
- ☐ Ulcers
- ☐ Gastritis
- ☐ Helicobactor pylori
- ☐ Nausea/vomiting
- ☐ Stomach surgery
- ☐ Liver problems
- ☐ Alcohol abuse
- ☐ Viral hepatitis
- ☐ IV drug abuse
- ☐ Jaundice
- ☐ Gallstones
- ☐ Weight loss (last 6 mo)
- ☐ Colon polyps
- ☐ Hemorroids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon cancer
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Bloody bowel movement
- ☐ Black bowel movement
- ☐ Hard stools
- ☐ Soft stools

☐ Other symptoms or complaints: _____

Have you recently had a colonoscopy performed for colon cancer screening ? Yes No

Year _____ **Next surveillance due** _____

Illnesses: *CHECK ANY OF THE FOLLOWING YOU HAVE HAD, IF IN DOUBT PUT A QUESTION MARK*

- ☐ Diabetes mellitus
- ☐ Cancer
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Kidney stones
- ☐ Endometriosis
- ☐ Heart disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Thyroid disease
- ☐ Other _____
- ☐ Serious accident
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ PTSD
- ☐ Gout

Surgeries: *CHECK ANY OF THE FOLLOWING YOU HAVE HAD, IF IN DOUBT PUT A QUESTION MARK*

- ☐ Tonsils
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Gallbladder
- ☐ Heart surgery
- ☐ Other surgery
- ☐ Hernia
- ☐ Hemorrhoid

DRUG or LATEX ALLERGIES: *PLEASE LIST ANY DRUG (including LATEX) ALLERGIES THAT YOU MAY HAVE*

_____

PLEASE CONTINUE ON TO COMPLETE THE FOLLOWING TWO PAGES

PLEASE ANSWER ALL QUESTIONS

HAVE YOU HAD ANY OF THE FOLLOWING DURING THE PAST ONE YEAR?
Check all the apply to you. If it does NOT apply to you please leave blank.

CONSTITUTIONAL
- ☐ Headache
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Increased Appetite
- ☐ Decreased Appetite

SKIN
- ☐ Rash
- ☐ Skin Changes
- ☐ Dry Skin
- ☐ Pigmentation
- ☐ Moles

EYES
- ☐ Change in Visual Activity
- ☐ Blurred Vision
- ☐ Diplopia (Double Vision)
- ☐ Halos Around Lights
- ☐ Irritation/Pruritis
- ☐ Drainage
- ☐ Discharge

ENT
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Ear Ache
- ☐ Attacks of Vertigo
- ☐ Frequent Sinus Infection
- ☐ Rhinorrhea
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Voice/Vocalization Changes
- ☐ Difficulty Chewing or Swallowing

CARDIOVASCULAR
- ☐ Chest Pain/Pressure
- ☐ Palpitations
- ☐ Dyspnea (Shortness of Breath)
- ☐ Sycope
- ☐ Edema
- ☐ Leg Cramps/Calf Pain

RESPIRATORY
- ☐ Cough
- ☐ Hemoptysis (Coughing up Blood)
- ☐ Pleuritic Chest Pain
- ☐ Wheezing
- ☐ Dyspnea (Shortness of Breath)

GASTROINTESTINAL
- ☐ Frequent Heartburn
- ☐ Abdominal Pain
- ☐ Jaundice
- ☐ Blood in Stool
- ☐ Black Tarry Stools
- ☐ Painful Bowel Movements
- ☐ Constipation
- ☐ Diarrhea

GENITOURINARY (Female)
- ☐ Burning with Urination
- ☐ Hematuria
- ☐ Incontinence
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Menstrual Problems
- ☐ Painful Intercourse

GENITOURINARY (Male)
- ☐ Pain/Burning with Urination
- ☐ Hematuria
- ☐ Weak Stream
- ☐ Nocturia
- ☐ Testicular Pain or Swelling
- ☐ Erectile Dysfunction

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Back Pain
- ☐ Neck Pain

NEUROLOGICAL
- ☐ Headaches
- ☐ Dizziness
- ☐ Syncope
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Difficulty Walking
- ☐ Memory Disturbance
- ☐ Speech Changes
- ☐ Tremor

HEMATOLOGIC/LYMPHATIC
- ☐ Anemia
- ☐ Easy Bruising/Bleeding
- ☐ Lymph node Enlargement

ENDOCRINE
- ☐ Polyuria
- ☐ Cold/Heat Intolerance
- ☐ Weight Changes
- ☐ Difficulty or Delayed Healing

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Unusual Stress

HABITS DO YOU USE? (please circle)

Cigarettes Yes No Packs per day _____

Cigars Yes No Amount per day _____

Chew (snuff) Yes No Amount per day _____

# of years using tobacco _____ When did you quit? _____

Alcohol Yes No Drinks per day _____ Drinks per week _____

Alcohol problem? Yes No current in the past

Coffee Yes No Cups per day _____

Tea Yes No Cups per day _____

Diet candies Yes No Amount per day _____

Mints Yes No Amount per day _____

Chocolate Yes No Amount per day _____

Sodas or carbonated drinks Yes No Amount and type _____

Dairy products Yes No

Please give amounts of dairy _____

A specific diet Yes No Type _____

SOCIAL HISTORY

Education (circle) High School Vocational College

Type of work Self _____ Employed? Yes No

Spouse _____ Employed? Yes No

Birthplace _____ Religion _____

Marital status (circle) Single Married Divorced Widowed Domestic partner

Is your sexual partner (circle) Male Female

FAMILY HISTORY Circle if anyone in your family has had the following:

Colon cancer Yes No Abnormal bleeding Yes No Other cancer _____

Colon polyps Yes No Liver Disease Yes No Add'l details _____

Ulcerative colitis Yes No Diabetes Yes No Other diseases _____

Crohns' disease Yes No Stomach cancer Yes No _____

Father: Alive Deceased Mother: Alive Deceased

Illnesses: _____ Illnesses: _____

Brothers and Sisters: How many? _____ Illnesses: _____

Children: Sons How many? _____ Illnesses: _____

Daughters How many? _____ Illnesses: _____

Is there anything else that you feel is pertinent for the doctor to know about you?

_____

_____

Patient signature _____

Physicians initials _____ date _____

Western Washington Medical Group

Department of Gastroenterology and Endoscopy

PLEASE KEEP THIS PAMPHLET FOR FUTURE REFERENCE

Thank you for choosing our office to provide you with your specialized medical needs. Your concerns are very important to us and we want to assure you that it is our intent to give you the best possible care for your medical condition. In an effort to assist you with questions that you may have once you return home, we are providing you with this informative tool. Please refer to this sheet prior to calling our office, except in the case of an emergency.

OFFICE HOURS and GENERAL INFORMATION

- Our office hours are 8:00 – 5:00 Monday through Friday. We are closed for the following holidays: New Years Day, President's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving Day and the Friday following, and Christmas Day.

- If you are in need of medical advice after hours dial **(425) 259-3122** and our answering service will pick up your call. They also cover calls during the noon hour. The answering service will take your message and contact the physician that is on call for the day. Please be aware that after hour calls may not be returned by the physician that you normally see in the office.

- **FOR ALL LIFE THREATENING EMERGENCIES CALL 911.**

SCHEDULING APPOINTMENTS

- To call our office to make an appointment or inquire about an existing appointment call **(425) 259-3122.** You may be asked to leave a voice message for the scheduling staff. They will make every effort to return your call by the end of the day.

- When arriving for an appointment you will be asked to arrive 15 minutes early for a new patient visit. If you have not been seen in the office in over one year, please arrive at least 10-15 minutes early to update your paperwork.

PRESCRIPTION REFILLS

- Prescription refills need to be handled through your pharmacy Monday through Thursday, it is best not to wait until Friday, as we do **not** refill prescriptions after hours or on the weekends. Your pharmacy will either call or fax us with the proper information needed to authorize your refill. If your medication requires a written prescription each time, you will need to call our office and leave a message with our Medical Assistants.

- *** ALL REFILLS REQUIRE 48 HOURS NOTICE*** (It takes time for your pharmacy to contact our office, our staff to discuss your request with the physician, and for us to call your pharmacy back or to have a script written and signed).

PHONE MESSAGES AND TEST RESULTS

- For urgent calls please dial **(425) 259-3122** and make sure that you convey the urgency of your call to the receptionist.

- It generally takes at least 3-5 business days for any lab, x-ray or procedure reports to arrive in our office. The results will then go to the Physician for review, and then a call placed to the patient with the results. Unless the results are abnormal (in which case you can expect a call from a Physician) you will likely receive a call back from the Medical Assistant telling you that your test was normal. The entire process can take one to two weeks for some tests.

- To leave a message for the Medical Assistants (MA), for a non-urgent issue, please ask the receptionist to allow you to leave a voice mail message. They do make an effort to return all calls the same day, if at all possible. Please do not make multiple phone calls as this may mean that several different MA's are looking for the same chart. This will delay your return call, as well as those of other patients.

BILLING

- To contact our patient accounts (billing) office please dial **(425) 259-0832.**

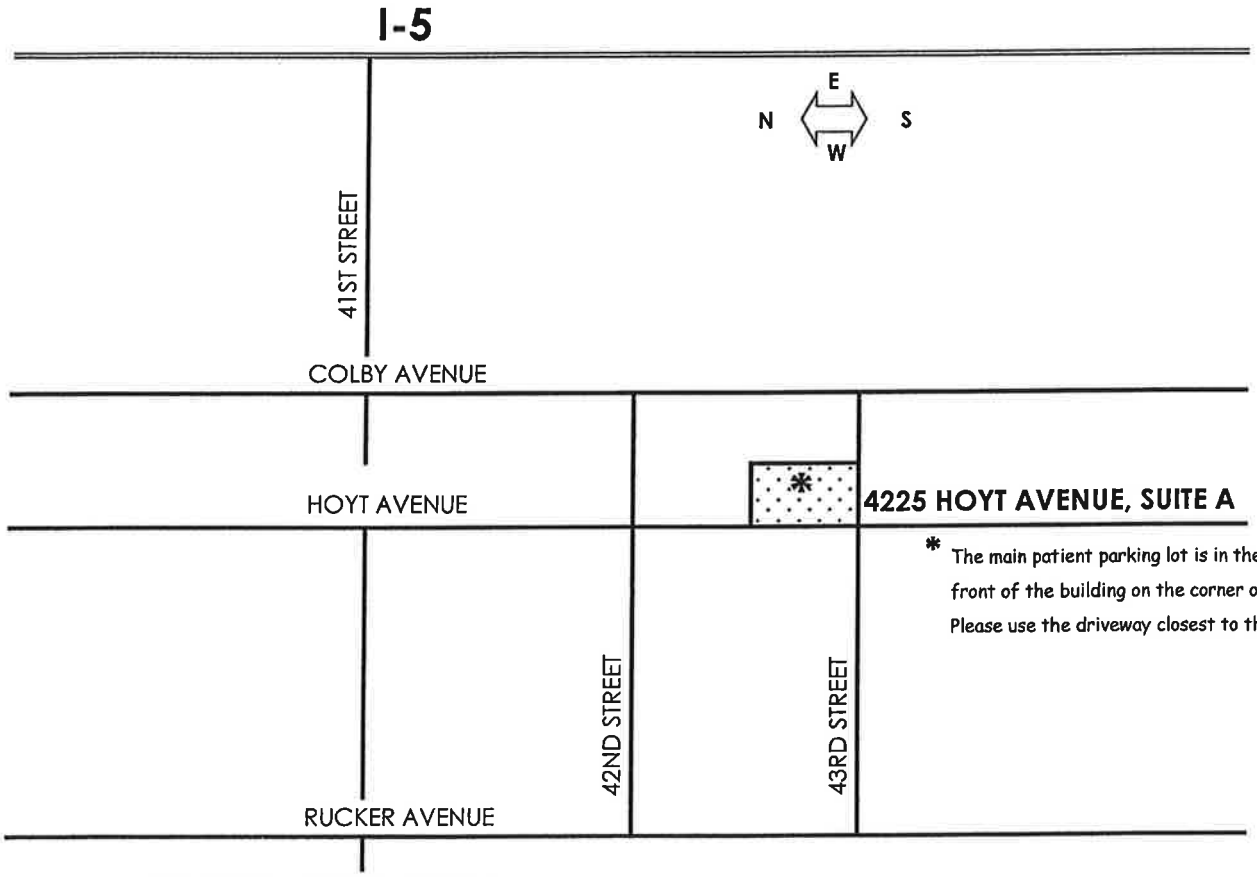
- All co-payments are required at the time of service, for every visit, some carriers now require a co-payment on all facility fees as well as office visits.

- Our billing office staff will make every effort to ensure that your insurance requirements are met prior to services being rendered; however, ultimately it is your responsibility to verify that the appropriate referrals and authorizations are obtained. It is in your best interest to inform us of any change to your insurance plan or Primary Care Physician as soon as possible. Your insurance may also require pre-authorization and/or pre-certification for procedures (note – these are considered "surgical" procedure codes), even if you don't need an actual referral for an office visit. The scheduling and referral staff will assist you in obtaining this pre-authorization, as well. Please note that unless your procedure is being performed at the hospital you will need to get pre-authorization for Western Washington Medical Group – Endoscopy Center, as well as for the physician who performs the procedure.

Western Washington Medical Group
Gastroenterology

DEPARTMENT OF GASTROENTEROLOGY
4225 HOYT AVENUE, SUITE A
EVERETT, WA. 98203-2318
(425) 259-3122
(425) 252-9860 fax

Gaurav Aggarwal, MD
Sujoy Ghorai, MD
Friedrich Loura, MD
Laura Larson, PA-C
W. Michael McDonnell, MD
James Z. Mu, MD
Edward A. Slosberg, MD
Jerome R. Waldbaum, MD



4225 HOYT AVENUE, SUITE A

FROM THE NORTH:

I-5 southbound take exit # 192 to 41st Street. Bear right onto 41st Street. Continue WEST to Colby Ave. Turn left onto Colby. Go two blocks to 43rd street and take a right. Go one block and take a right onto Hoyt Avenue. Western Washington Medical Group - GI Dept. is on the NE corner of 43rd and Hoyt.

FROM THE SOUTH:

I-5 northbound take exit # 192 to 41st Street. Stay in the left lane on the off ramp.
Turn left, heading WEST onto 41st Street, Continue west to Colby Avenue.
Turn left onto Colby. Go two blocks to 43rd street and take a right. Go one block and take a right onto Hoyt Avenue. Western Washington Medical Group - GI Dept. is on the NE corner of 43rd and Hoyt.