Western Washington Medical Group
Gastroenterology

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, WA 98203

PROVIDENCE REGIONAL MEDICAL CENTER-EVERETT
Hospital Tower Admit
1700 13th St
Everett, WA 98201

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 to read, fill out at your leisure at home, and **bring to your appointment**. Here is a checklist of the forms that are enclosed and short explanation of each:

- **Blood Thinners and Cardiac Devices:** This is required for any scheduled procedure. If this does not apply to you, leave it blank.
- **Registration Form:** Please remember to bring **all of your insurance cards**. We will need to scan a copy of the front and back of the card(s). If **your insurance plan requires a copayment**, this will be collected at time of your appointment. If your **insurance plan requires a referral** it is your responsibility to obtain one from your primary care provider, prior to this office visit. If you have difficulty obtaining the referral from your primary care provider, please call our referral coordinator at (425) 259-3122 for assistance.
- **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 disclosure form.
- **Medical History Form:** It is important to complete the form in full. This will enable us to care for you appropriately. If you require additional space, please write on a separate sheet of white paper and attach it to the history form.
- **Medications Form:** Please list all of your current prescribed medications that you are taking. Include the dosage and how often you take them. You should also list any herbal or over the counter medications, vitamins, minerals, etc. that you take on a regular basis.
- **The Financial Policy:** This is your acknowledgment 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.
- **No Show Policies:** For the office and procedures.
- **General Information:** This tells you more about our office policies and procedures.
- **Directions and Map:** 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 efficient. Thank you for your time and attention, we look forward to participating in your medical care.

Western Washington Medical Group
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Blood Thinners and Cardiac Devices

The following information is required to schedule any procedure(s) that your GI provider may order.

For your safety, we need to get a clearance to hold your prescription blood thinner **PRIOR** to scheduling your appointment.

If you are taking any of the **following** medications please check the box below.

Name of Medications:

- ☐ Warfarin (Coumadin, Jantoven)
- ☐ Plavix (Clopidogrel)
- ☐ Pradaxa (Dabigatran)
- ☐ Eliquis (Apixaban)
- ☐ Effient (Prasugrel)
- ☐ Savaysa (Edoxaban)
- ☐ Brilinta (Ticagrelor)
- ☐ Cilostazol (Pletal)
- ☐ Other _____

Name of physician/PA-C/ARNP on your prescription bottle and their location/Medical Group:

_____

Device Clearance

For your safety, we need to get a clearance for your Cardiac Defibrillator/Pacemaker **PRIOR** to scheduling your appointment.

We need to know

Name/Type of Cardiac Device: _____

Name of Provider/Facility who manages your device and their location/Medical Group:

_____

Please note that if we do not receive this information, your procedure(s) may not be scheduled, or may be canceled, until correct information is received.

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

PRIMARY CARE DOCTOR

HOW DID YOU HEAR OF US?
Internet ☐ Google Maps ☐
Friend/Family ☐
Drove by location ☐
Insurance Company ☐
Mailer/ Marketing ☐

MARITAL STATUS
MARRIED ☐ DIVORCED ☐ OTHER ☐
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 by voicemail, text, email or portal, which may contain details of my medical condition.
By voluntarily providing your mobile phone number to WWMG, you agree to receive recurring non-marketing SMS messages regarding appointment reminders, cancellation or rescheduling, patient onboarding, care-related notifications, and billing updates. Message frequency varies. Message and data rates may apply. Providing a mobile number and consenting to SMS messages are not required to receive medical treatment or services from WWMG. Reply HELP for help or STOP to opt out. View the WWMG Privacy Policy and SMS Terms and Conditions.

INITIALS VOICEMAIL #

PATIENT SIGNATURE ***DATE***
Type name for signature

For office use only

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

Western Washington Medical Group
Gastroenterology

FRIENDS AND FAMILY RELEASE

The name(s) listed below are family members or friends to whom I wish to grant access to my healthcare information.

I will rely on the professional judgement of my provider and their 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 medical record. I, the patient, may be asked to sign a Release of Information (ROI) to allow WWMG to share information if my provider and their designee deem it necessary.

This consent will be considered valid until such time that I, the patient, revoke it. I reserve the right to revoke this 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 from the above information.

Please provide YOUR most current phone contact information. This information will become part of your permanent medical record until you change it. You can change this information by completing a new form at any time.

Please note: By choosing the option to leave a detailed message, you are allowing us to leave sensitive health information and specific details related to referrals.

First phone number: _____ Cell Home Work OK to leave detailed message: YES NO

Second phone number: _____ Cell Home Work OK to leave detailed message: YES NO

Third phone number: _____ Cell Home Work OK to leave detailed message: YES NO

_____
PATIENT OR GUARDIAN SIGNATURE

_____
RELATIONSHIP TO PATIENT

_____
PRINTED NAME

_____
DATE

Western Washington Medical Group
Gastroenterology

MEDICAL QUESTIONNAIRE

Name: _____ Date of birth: _____ Age: _____

Referring physician: _____ Primary Care physician: _____

Reason for visit: _____

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

_____

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

- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Food sticking
- ☐ Regurgitation
- ☐ Heartburn
- ☐ Ulcers
- ☐ Helicobacter pylori
- ☐ Nausea/vomiting
- ☐ Bloating/gas
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Liver problems
- ☐ Viral hepatitis
- ☐ IV drug use
- ☐ Weight loss (last 6 months)
- ☐ Colon polyps
- ☐ Hemorrhoids
- ☐ Food intolerance
- ☐ Irritable bowel syndrome
- ☐ Pancreatitis
- ☐ Barrett's esophagus
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon cancer
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ Bloody stool
- ☐ Black stool
- ☐ Hard stools
- ☐ Soft stools
- ☐ Anal problem

☐ Other symptoms/complaints: _____

Have you had a colonoscopy? Yes ☐ No ☐ Year _____ Next surveillance due _____

Have you had an upper endoscopy (EGD)? Yes ☐ No ☐ Year _____

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

- ☐ Diabetes
- ☐ Cancer
- ☐ High blood pressure
- ☐ Lung disease
  Type:_____
- ☐ Sleep apnea
- ☐ Heart disease
- ☐ Chronic cough
- ☐ Chronic infection
- ☐ Thyroid disease
- ☐ Bone/Joint disease
- ☐ Serious accident
- ☐ Stroke
- ☐ Parkinson's
- ☐ PTSD
- ☐ Blood clot(s)
- ☐ Endometriosis

☐ Other: _____

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

- ☐ Appendectomy
- ☐ Bowel resection
- ☐ Gallbladder
- ☐ Hernia
- ☐ Heart surgery
- ☐ Cardiac stent(s)
- ☐ Pacemaker/Defibrillator
- ☐ Hemorrhoids

☐ Other: _____

PLEASE CONTINUE TO NEXT PAGE

HABITS: DO YOU USE? (please circle)

Tobacco/smokeless	YES	NO	Amount per day _____
# of years using tobacco	_____		Quit date? _____
Marijuana	YES	NO	Type: _____
			How much?_____ How often?_____
Alcohol	YES	NO	Drinks per day _____ Drinks per week _____
Alcohol abuse	YES	NO	Current? _____ Past? _____
Coffee	YES	NO	Cups per day _____
Tea	YES	NO	Cups per day _____
Sodas/carbonated drinks	YES	NO	Type/Amount per day _____
Gluten free diet	YES	NO	Other _____
Dairy products	YES	NO	Amount _____
Special diet	YES	NO	Amount per day _____
			Type _____

SOCIAL HISTORY

Education (circle)	High School	Vocational	College			
Type of work		Self _____		Employed	YES	NO
		Spouse _____		Employed	YES	NO
Birthplace _____		Biological gender at birth _____		Current gender identity _____		
Marital status (circle)	Single	Married	Divorced	Widowed	Domestic Partner	

Do you have religious/spiritual beliefs that would affect your decisions concerning your health care? If so, in what way?

_____

FAMILY HISTORY (circle if any family member has had the following)

Colon cancer	YES	NO	Esophageal cancer	YES	NO	Other cancer _____
Colon polyps	YES	NO	Liver disease	YES	NO	Add'l details _____
Ulcerative Colitis	YES	NO	Pancreatic cancer	YES	NO	Other diseases _____
Crohn's disease	YES	NO	Stomach cancer	YES	NO	_____

Father	Gastrointestinal illnesses _____
Mother	Gastrointestinal illnesses _____
Siblings	Gastrointestinal illnesses _____
Children	Gastrointestinal illnesses _____

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

_____

Patient signature _____ Date _____

Provider initials _____

DATE:

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PATIENT NAME: **DATE OF BIRTH:**

PHARMACY NAME **PHARMACY PHONE #**

LOCATION **PHARMACY FAX #**

Please list all medications including **over the counter medications, vitamins, antacids and 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

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, such as Preventative Care, 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 fee of **$250.00** will be charged for either a late cancellation (someone who misses a procedure appointment without canceling **5 business days** in advance) or "No Show" (someone who fails to present at time of a scheduled 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 service, collection fees, reasonable attorney fees and court costs.

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

I understand if I have received anesthesia, I will receive a separate bill from Paceline Anesthesia PLLC for its anesthesia services.

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

WWMG-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).

Advanced cancellations: If an office appointment is cancelled or rescheduled **48 hours before** the scheduled time, it is considered an advanced cancellation and there will be no cancellation or reschedule fee.

Late cancellations: If an office appointment is cancelled 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 $100.00.

No Show: If patient fails to present at the time of a scheduled appointment without prior notice, it is considered a "no show." The patient will be charged a "no show" fee of $100.00.

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 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, notifying the patient of discharge from the practice. Emergency gastroenterology care will be provided for an additional 30 days from the date of Termination of Care letter.
- 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 $100.00 deposit for the first office appointment (this requirement is only for those who did not pay fees within 60 days and were discharged). If the patient cannot afford or is 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 08/01/2024

Western Washington Medical Group

Endoscopy Center

WWMG-GASTROENTEROLOGY

Endoscopy Procedure Late Cancellation and No Show Policies

A late cancellation or "no show" is someone who misses a procedure appointment without cancelling **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, and/or Island Hospital.

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

Signature:_____ Date: _____

Print Name:_____ DOB:_____

Revised 08/01/2024

Western Washington Medical Group

Gastroenterology

FREQUENTLY ASKED COLONOSCOPY PREPARATION QUESTIONS

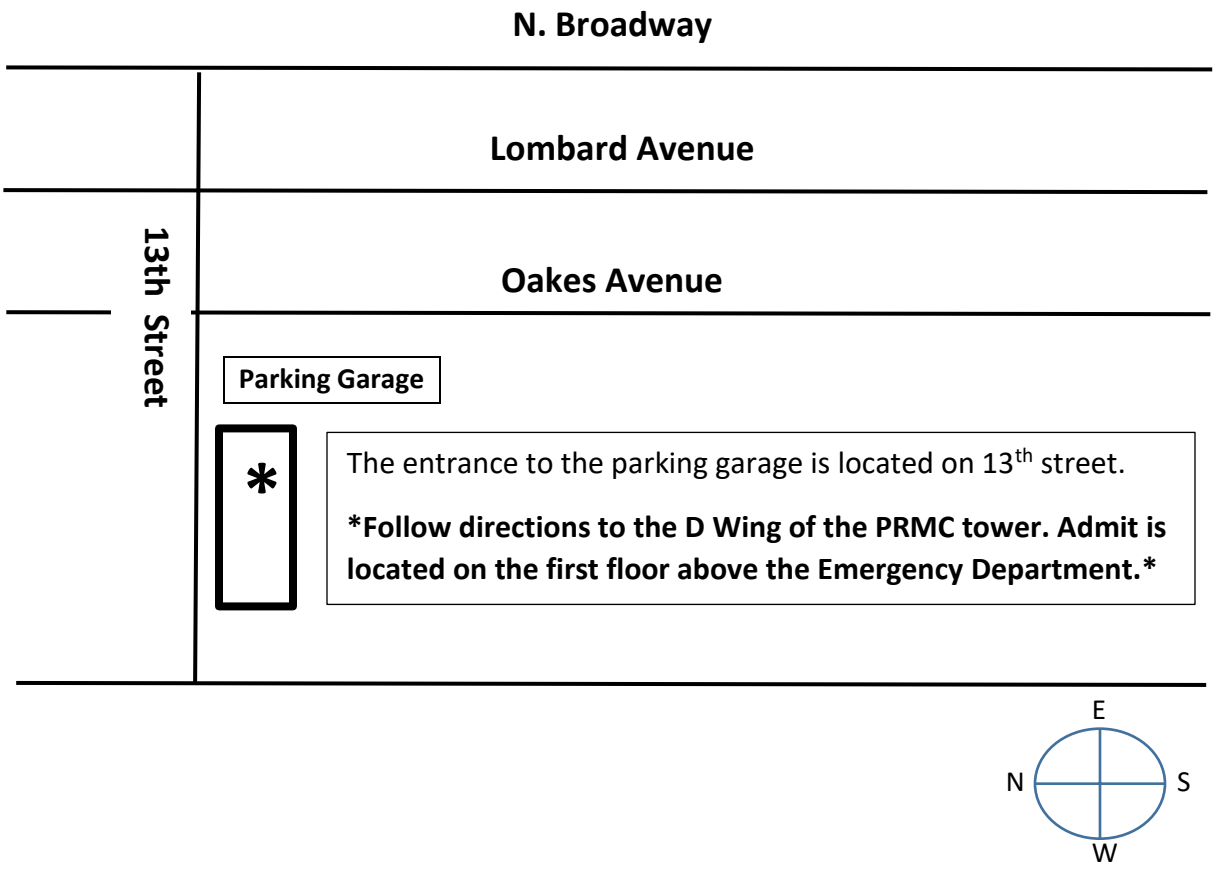
Please read your 5 Day preparation planner immediately upon receiving

1. **When is the last time I can have clear liquids to drink?**
   - You may have clear liquids up to 4 hours prior to your check-in time. Please avoid all liquids that are **RED**, **BLUE**, or **PURPLE** in actual color.
2. **Can I start my prep earlier/later?**
   - Yes, but no earlier than 1 hour before start time and no later than 1 hour after start time.
3. **If I start to vomit, what should I do?**
   - If you vomit only a few times, take a break, lengthen time between glasses until this resolves. If vomiting is continual and excessive, call the on-call physician at (425) 259-3122.
4. **I drank almost all of my prep and still have not gone to the bathroom. What should I do?**
   - During business hours, 8am-5pm, call GI Prep Line (425) 259-3122. If it is after hours, call the GI office for the on-call physician at (425) 259-3122.
5. **What happens if my prep is not adequate?**
   - It is very important that you are clean which should occur if you follow the exact 5 day prep planner. This will improve the chance of visualizing colon polyps or abnormalities during your exam. If your prep is not adequate, your procedure may be canceled and rescheduled or your procedure time will be delayed in order to allow time to drink more prep solution. If the procedure is attempted but aborted due to a poor prep, you may be asked to return for a second procedure, using more bowel prep and your insurance may or may not cover the second procedure.
6. **My family member did a different prep. Can I do the one that they did instead?**
   - No, your prep regimen has been prescribed specifically for you by the doctor.
7. **The pharmacist gave me a different bowel prep, and/or the instructions on the container/box are different from the instructions on my prep planner. What should I do?**
   - Call the office (425) 259-3122 immediately to receive instructions that coincide with your prescribed bowel prep. Do not follow the instructions on the container/box, follow instructions given to you from the office.
8. **What if I do not have a driver or they cannot stay for the entire time?**
   - Your procedure will be canceled if your driver is not in the building at all times. **This is a strict policy.** You have the option of rescheduling your exam. In certain circumstances the procedure can be done without sedation, though if unsuccessful, you may be asked to return for a second procedure, with a driver and you will be charged for the second procedure.
9. **Will I be asleep?**
   - You will receive anesthesia/Propofol. This is guaranteed sleep through the entire procedure and has a quicker recovery, usually no nausea and no memory loss.
10. **What if I am on my monthly menses?**
    - This will not affect your procedure in any way (tampon or pad okay).
11. **Should I bring my CPAP machine?**
    - No, you will not need it during the procedure.

Revised 04/16/2026

Providence Regional Medical Center Everett

1700 13TH STREET
EVERETT, WA 98201
MAIN HOSPITAL (425) 261-2000



NORTHBOUND I-5:
Take Exit 192 from Interstate 5. Stay right onto Broadway overpass. Stay on Broadway to 13th Street. At light, take left onto 13th Street and proceed to parking garage.

SOUTHBOUND 1-5:
Take Exit 194 from Interstate 5. Stay right at the "Y". At stop sign, turn right onto Everett Avenue. Turn right onto Broadway. Turn left onto 13th Street and proceed to parking garage.