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, Washington

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

ANACORTES
1213 24th St, Suite 700 (Island Surgeons)
Island Hospital Main Entrance

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:

- Blood Thinners and Cardiac Devices: We will require this for any procedure scheduling. If this does not apply to you, just leave it blank.
- 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.
- No Show policies for the office and procedures.
- 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.
- 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
DEPARTMENT OF GASTROENTEROLOGY/ENDOSCOPY

REGISTRATION FORM

ACCOUNT#_____ NEW ____ UPDATE ____

PATIENT LAST NAME	FIRST NAME (legal)	MI	PREFERRED OR NICKNAME

DATE OF BIRTH	SEX M F	RACE / ETHNICITY	SOCIAL SECURITY # / PREFERRED LANGUAGE

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 ( )

REFERRING DOCTOR	MARITAL STATUS MARRIED ____ DIVORCED ____ OTHER ____
PRIMARY CARE DOCTOR	SINGLE ____ WIDOWED ____ SEPARATED ____
PHARMACY NAME, PHONE NUMBER AND LOCATION	PREFERRED EMAIL ADDRESS

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 MALE___ FEMALE___	SUBSCRIBERS ID #	GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY

SUBSCRIBER'S NAME	SUBSCRIBERS EMPLOYER

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBERS SEX MALE___ FEMALE___	SUBSCRIBERS ID #	GROUP NUMBER

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

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

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

Blood Thinners and Cardiac Devices

Dear Patient:

We will require the following information in order to schedule any procedure(s) that your GI Provider may order.

For your safety, in order to schedule your procedure, we need to get a clearance to hold your Prescription Blood thinner **PRIOR** to scheduling your appointment.

If you are on one of the **following** medications please check the box below.

Name of Medications:

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

Name of Doctor/PAC/ARNP on your prescription bottle and their location/Medical Group:

_____

Device Clearance

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

We will 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
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 **No-Show Fee** for procedures of **$250.00** will be charged if not cancelled a minimum of 72 hours 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)

I understand that if I have received anesthesia, that 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_____

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).

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.
- 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

WWMG-Gastroenterology

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, 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:

Western Washington Medical Group
Gastroenterology

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

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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

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 _____

is now:
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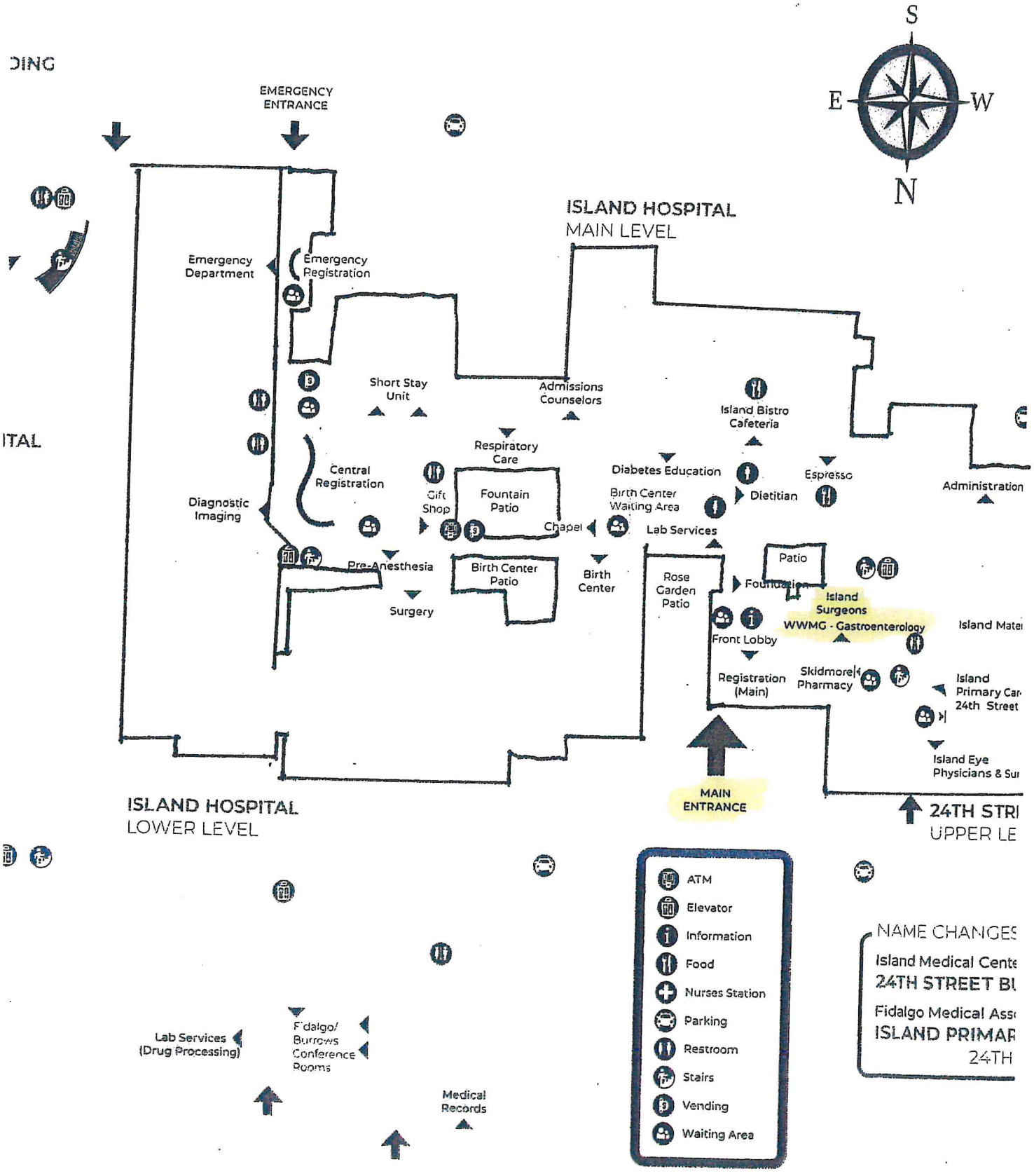
ISLAND HEALTH
Care Courageously™

ISLAND HEALTH
MAIN CAMPUS



NAME CHANGES
Island Medical Cente
24TH STREET BU
Fidalgo Medical Ass
ISLAND PRIMAR
24TH