CapitolGI
Capitol Gastroenterology Consultants Medical Group, Inc.

John Canio, M.D. • Theodor Feinstat, M.D. • Ronald Hsu, M.D., F.A.C.P., F.A.C.G., F.A.S.G.E., A.G.A.F. • Anand Madan, M.D., F.A.C.P.
Rakesh Parikh, M.D. • Jasbir S. Rangi, M.D. • Randell P. Vallero, M.D. • Sidney Yassinger, M.D., F.A.C.P. • Todd W. Zimmerman, M.D., F.A.C.P.

Dear Patient,

We the physicians & staff of Capitol Gastroenterology Consultants Medical Group, Inc. value the confidence and trust you have placed in us. Throughout your health care experience we strive to meet your medical needs and exceed your expectations with courteous, attentive, personal care.

Instructions

In order to better serve you we have enclosed the following forms with this letter:

- Patient Registration Form
- Patient Medical Questionnaire
- Office Directions
- Patient Payment Policy
- Summary Notice of Privacy Practices
- Acknowledgement of Receipt of Notice of Privacy Practice

PLEASE RETURN THE FOLLOWING ITEMS TO US IN THE ENCLOSED ENVELOPE, AS SOON AS POSSIBLE. THANK YOU!

- ☐ **Patient Registration Form**
- ☐ **Patient Medical Questionnaire**
- ☐ **Acknowledgement of receipt of Notice of Privacy Practices /Acknowledgement of receipt of Patient Payment Policy**
- ☐ **A copy of the front and back of your insurance card**

We are committed to providing you with the highest quality of care and we wish to ensure that your experience with us is a positive one; therefore, it is important that you remember to bring your current insurance card on every visit to our office and your co-payment or deductible is due at the time of your visit.

In order to make your visit more productive with your physician, please bring with you any **recent labs, x-rays or test results** and **the referral** from your primary care physician. Your satisfaction with the care and services you receive at Capitol Gastroenterology is very important to us. We promise to provide you with excellent medical care and outstanding service.

Sincerely,

The Management Team, Physicians and Staff of
Capitol Gastroenterology Consultants Medical Group, Inc.

Carmichael Office
6555 Coyle Avenue, Suite 330
Carmichael, CA 95608
(916) 965-9650 • Fax (916) 965-0335

Lincoln Office
685 Twelve Bridges Drive, Suite D
Lincoln, CA 95648
(916) 773-6200 • Fax (916) 782-4550

Roseville Office
4 Medical Plaza Drive, Suite 205
Roseville, CA 95661
(916) 773-6200 • Fax (916) 782-4550

Please read the back of this page.

Summary of Notice of Privacy Practice

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that, effective April 14, 2003, we provide you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. A copy of our full Notice is available upon request, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgement that you have received this summary.

Your Rights as a Patient
You have rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information
We are permitted to use your protected health information for treatment purposes, payment and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operation of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them permissible.

Disclosures of Protected Health Information Requiring Your Authorization
For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosures of Protected Health Information Not Requiring Your Authorization
We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Restriction to Use and Disclosure
You may request restrictions to the use or disclosures of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, only the minimum amount of such information will be used to accomplish the intended goal.

Access to Protected Health Information
You may request access to or a copy of your medical records in writing. If we deny the request, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments to Medical Records
You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denial and have your objections noted in your medical record.

Accounting of Disclosures of Protected Health Information
You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment or operations.

Complaints Related to Perceived Violation of Your Privacy Rights
You may register a complaint about any of our privacy practices with our Privacy Officer or with the Secretary of Health and Human Services.

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Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

If you are unable to keep your appointment, please call at least 48 hours before to notify one of our staff members. Our policy is to charge $25 for missed appointments not canceled within this time frame. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with the Billing Office or the Practice Administrator.

How May I Pay?
We accept payment by cash, check, or credit card (VISA, MasterCard, Discover).

Do I need a Referral?
If you have an HMO Plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received a referral prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you may have to be rescheduled.

Which Plans Do You Contract With?
We participate and accept most insurance plans and we are happy to verify eligibility for you but we also suggest that you contact your carrier to make sure that your services will be covered prior to your visit.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have...	*You Are Responsible For...*	*Our Staff Can Assist With...*
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, x-ray, injection, and other charges are requested at the time of the office visit.	Calling your insurance company ahead of time to determine deductibles and coinsurance. Filing an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable co-pays, co-insurance and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Calling your insurance company ahead of time to determine co-pays, deductibles, and non-covered services for you and try to obtain a referral and authorization on your behalf, but it is your responsibility to make sure we have a referral for your first visit. Filing an insurance claim on your behalf.

Please read the back of this page.

If You Have...	*You Are Responsible For...*	*Our Staff Can Assist With...*
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Providing the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility – deductible, co-pay, non-covered services – is requested at the time of the visit.	Calling your insurance company ahead of time to determine out of network benefits, co-pays, deductibles, and non-covered services. File an insurance claim on your behalf.
Medicare	If you have Regular Medicare, and have not met your $140 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare payment is requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit. If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% co-pay is requested at the time of the visit.	Filing the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO/ Advantage Plan	All applicable co-pays and deductibles at the time of the office visit.	Filing the claim on your behalf, as well as any claims to your secondary insurance.
Occupational injury	Payment in full is requested at the time of the visit.	Providing you a receipt so you can file the claim with your carrier.
No Insurance	Payment in full is requested at the time of the visit.	Working with you to settle your account. Please ask to speak with the billing staff if you need assistance.

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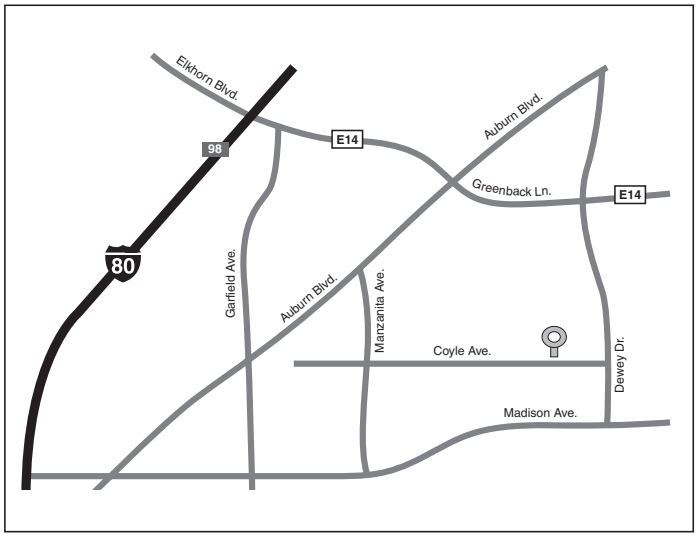
Directions to:

Carmichael Office

6555 Coyle Avenue, Suite 330
Carmichael, CA 95608
(916) 965-9650



Highway 50W

Exit Sunrise; turn right on Sunrise, turn left on Madison, turn right on Dewey Drive, and turn left on Coyle Ave.

I-80 W

Exit Greenback Lane, turn left on Greenback Lane, turn right on Dewey Drive, turn right on Coyle Ave.

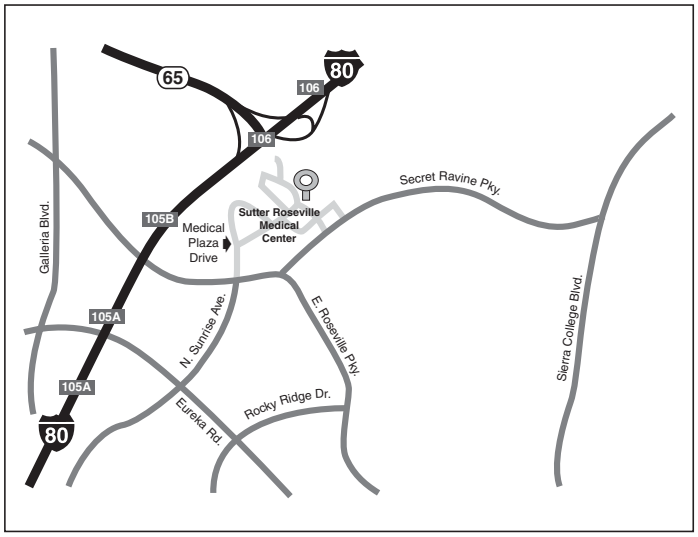
I-80 E

Exit Madison Ave., turn right on Madison Ave, turn left on Dewey Drive, turn left on Coyle Ave.

Directions to:

Roseville Office

4 Medical Plaza Drive, Suite 205
Roseville, CA 95661
(916) 773-6200



Roseville Office from Sacramento:

Take 80 East (Reno) to Atlantic/Eureka exit. Turn right on Eureka. Turn left on N. Sunrise. Go through the East Roseville Parkway light, stay in right lane and turn right on Medical Plaza Dr. 2nd building on the right, building 4, Suite 205.

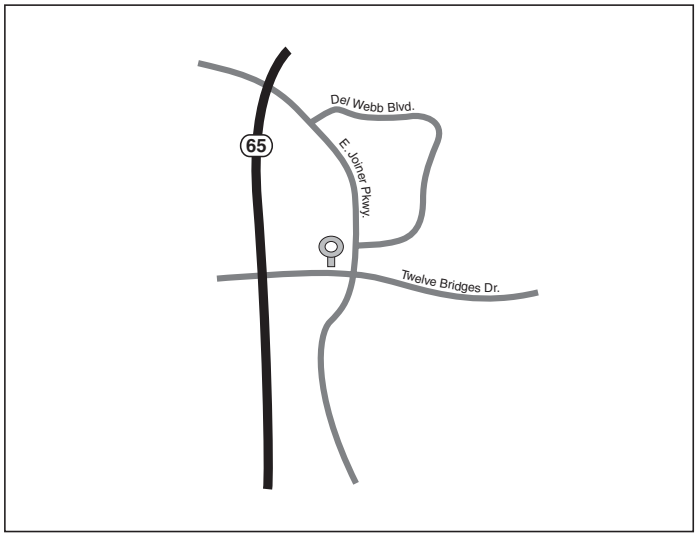
Roseville Office from Rocklin/Auburn:

Take 80 West (Sacramento) to Eureka Rd. exit. Loop back over the freeway. Turn left on N. Sunrise. Go through East Roseville Parkway light, stay in the right lane and turn right on Medical Plaza Drive 2nd building on the right, building 4, Suite 205.

Directions to:

Lincoln Office

685 Twelve Bridges Drive, Suite D
Lincoln, CA 95648
(916) 773-6200



Lincoln Office from Sacramento:

Take Hwy 80 E to Hwy 65. Go N. to Twelve Bridges Dr. and exit to the right. Follow it down approximately 3/4 of a mile and our office is located on your right side in the Sutter Medical Plaza building. The address is 685 Twelve Bridges Dr., Suite D. The entrance to our suite is located in the rear of the building with ample parking.

Lincoln Office from Marysville/Yuba City:

Take Hwy 80/65 S. Twelve Bridges Dr. at stop sign make a left go up over the freeway and follow it down approximately 3/4 of mile. The office is located on the right hand side in the Sutter Medical Plaza building. The address is 685 Twelve Bridges Dr., Suite D. The entrance to our suite is located in the rear of the building with ample parking.

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Patient Registration

Please check and complete all parts of this Patient Registration Form

PLEASE RETURN COMPLETED FORMS TO US IN THE ENCLOSED ENVELOPE AS SOON AS POSSIBLE THANK YOU.

Date: _____

Patient Information:

Name: _____ DOB:_____Age: _____

Address: _____ City: _____ State:_____ Zip Code: _____

Email: _____ SSN:_____

Gender: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Best method to communicate with you: Email ☐ Mail ☐ Phone: Home ☐ Work ☐ Cell ☐

Preferred Language: _____ Race: _____ Ethnicity:_____

Occupation:_____ Employer:_____

Employer Address: _____

May we contact you at work? Yes No

Spouse Name: _____ Phone No.:_____

Spouse Employer: _____

Employer Address: _____

Pharmacy / Physician Information:

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State:_____ Zip Code: _____

Referring Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____ Fax:_____

Pharmacy Location: _____

Emergency Contact Information: (Someone not living with you)

Name: _____ Relationship: _____

Address: _____ City: _____ State:_____ Zip Code: _____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

Insurance Information: Please complete thoroughly.

PLEASE SEND A COPY OF FRONT AND BACK OF YOUR INSURANCE CARD! THANK YOU!

Primary Insurance: _____

Insurance Policy #: _____ Group #:_____

Name of Medical Group: _____

Primary Subscriber/Insured's Name: _____ DOB: _____ Sex: Male ☐ Female ☐

Relation to patient: Self ☐ Spouse ☐ Child ☐ Other: _____

Co-pay Amount: _____

Secondary Insurance: _____

Insurance Policy #: _____ Group #:_____

Name of Medical Group: _____

Primary Subscriber/Insured's Name: _____ DOB: _____ Sex: Male ☐ Female ☐

Relation to patient: Self ☐ Spouse ☐ Child ☐ Other: _____

Co-pay Amount: _____

PLEASE FILL OUT THE BACK OF THIS PAGE

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Acknowledgement of receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Under HIPAA, healthcare providers are required to give patients notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I _____ **(print name)** acknowledge that Capitol Gastroenterology Consultants Medical Group, Inc. has provided a written copy of their Notice of Privacy Practices.

X _____ _____ _____

Signature of Patient or Personal Representative | Printed Name | Date

_____

Relationship to Patient

_____

Name of Patient (if different from signee)

Acknowledgement of receipt of Patient Payment Policy

Our office will file all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered service amounts. See our Patient Payment Policy for details.

I have read, understand, and agree to the Patient Payment Policy. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Capitol Gastroenterology Consultants Medical Group, Inc.

I authorize Capitol Gastroenterology Consultants Medical Group to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

By signing below, I hereby authorize Capitol Gastroenterology Consultants Medical Group, Inc. to obtain medication history related to the patient above, from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

X _____ _____ _____

Signature of Patient or Personal Representative | Printed Name | Date

_____

Relationship to Patient

_____

Name of Patient (if different from signee)

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Capitol Gastroenterology Consultants Medical Group, Inc.

Patient Questionnaire

Date: _____

Name: _____ DOB: _____

Reason for Consultation: _____

_____

Do you have any of the following symptoms?

	YES	NO		YES	NO
Heartburn	☐	☐	Constipation	☐	☐
Pain with swallowing liquids / solids	☐	☐	Loss of appetite	☐	☐
Foods / liquids sticking with eating or drinking	☐	☐	Weight loss - Amt: _____	☐	☐
Regurgitation of food	☐	☐	Fever or night sweats	☐	☐
Abdominal pain	☐	☐	Yellow (jaundice)	☐	☐
Nausea & vomiting	☐	☐	Swelling of abdomen or feet	☐	☐
Black bowel movements	☐	☐	Shortness of breath	☐	☐
Red blood in bowel movements	☐	☐	Chest pain	☐	☐
Change in bowel habits	☐	☐	Urinary symptoms	☐	☐
Diarrhea	☐	☐			

Current Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to Medications:

_____ _____ _____

Labs and Exam History:

	DATE	FACILITY		DATE	FACILITY
Colonoscopy	_____	_____	Stool Testing	_____	_____
Upper Endoscopy (EGD)	_____	_____	Liver Biopsy	_____	_____
ERCP	_____	_____	Paracentesis	_____	_____
EUS	_____	_____	Esophageal Manometry	_____	_____
Flexible Sigmoidoscopy	_____	_____	Bravo/PH	_____	_____
Laparoscopy	_____	_____			

Please fill out back of this page.

Gastroenterology History:

- ☐ Anal fissure
- ☐ Appendicitis
- ☐ Ascites
- ☐ Barrett's disease
- ☐ Carcinoid
- ☐ Celiac disease
- ☐ Cirrhosis
- ☐ Colon polyps
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Duodenal ulcer
- ☐ Dyspepsia
- ☐ Dysphagia
- ☐ Esophageal varicies
- ☐ Esophagitis
- ☐ Gall bladder disease
- ☐ Gallstones
- ☐ Gastric ulcer
- ☐ Gastritis
- ☐ Gastroenteritis
- ☐ GERD
- ☐ GI bleed
- ☐ Giardiasis
- ☐ GIST
- ☐ Heartburn
- ☐ Heme positive stool
- ☐ Hemorrhoids
- ☐ Hepatic encephalopathy
- ☐ Hepatitis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis D
- ☐ Hepatitis E
- ☐ Hernia
- ☐ Inflammatory bowel disease
- ☐ Intestinal disorder
- ☐ Irritable bowel syndrome
- ☐ Liver disease
- ☐ Pancreatic pseudocyst
- ☐ Pancreatitis
- ☐ Peritoneal adhesions
- ☐ Pseudomem colitis
- ☐ PUD
- ☐ Ulcerative colitis
- ☐ Whipple's disease

Medical History:

- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Back pain
- ☐ BPH
- ☐ Bipolar disorder
- ☐ Cancer - breast
- ☐ Cancer - colon
- ☐ Cancer - leukemia
- ☐ Cancer - lung
- ☐ Cancer - lymphoma
- ☐ Cancer - prostate
- ☐ Cancer - skin
- ☐ Cellulitis
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ DVT
- ☐ Endocarditis
- ☐ Endometriosis
- ☐ Eye disorders
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Headache
- ☐ Heart attack (MI)
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hip replacement
- ☐ HIV
- ☐ Hyperkalemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Hypokalemia
- ☐ Hypothyroidism
- ☐ Impotence
- ☐ Kidney disease
- ☐ Lumbar disk disease
- ☐ Lung disorders
- ☐ Lupus
- ☐ Macular degeneration
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Nephrolithiasis
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peripheral neuropathy
- ☐ Pneumonia
- ☐ Renal disease
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Spinal stenosis
- ☐ Stroke (CVA)
- ☐ TIA
- ☐ UTI - recurrent
- ☐ Vertigo

Surgical History:

- ☐ AAA repair
- ☐ Abdominal exploration
- ☐ Aortic valve replacement
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Back surgery
- ☐ Breast biopsy
- ☐ CABG
- ☐ Caesarean section
- ☐ Carotid endarterectomy
- ☐ Cholecystectomy
- ☐ Colon resection
- ☐ Defibrillator
- ☐ Fundoplication
- ☐ Gastric bypass
- ☐ Heart valve replacement
- ☐ Hernia
- ☐ Herniorrhaphy
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee replacement
- ☐ Lumpectomy
- ☐ Lung surgery
- ☐ Mastectomy
- ☐ Mitral valve replacement
- ☐ Pacemaker
- ☐ Prostate surgery
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Vaginal delivery
- ☐ Vasectomy

Have you ever had any problems with anesthesia: **Yes ☐ No ☐**

Allergic to latex or rubber products: **Yes ☐ No ☐**

Allergic to eggs or shellfish: **Yes ☐ No ☐**

Family History:

Please place a check in the box next to each condition as it applies to each of your family members.

	Father	Mother	Brother	Sister	Grandfather (maternal or paternal)	Grandmother (maternal or paternal)	Uncle	Aunt	Cousin (male or female)	Other
Alcoholic Liver Disease										
Autoimmune Disease										
Celiac Disease										
Cirrhosis										
GERD										
Hep B										
Hemochromatosis										
Hep C										
IBD										
PUD										
Pre-Cancerous Polyps										
Cancer-Biliary										
Cancer - Bladder										
Cancer - Breast										
Cancer - Colon										
Cancer - Esoph										
Cancer - Gastric										
Cancer - Kidney										
Cancer - Liver										
Cancer - Lung										
Cancer - Ovarian										
Cancer - Pancreas										
Cancer - Prostate										
Cancer - Skin										
Cancer - Small Bowel										
Cancer - Uterine										
Cancer - Other										

Social History:

Identify any substances you have used and circle whether in the past (P) or are currently using (C).

Which of the following substances do you use and identify frequency (Ex. 2x/d, 1x/mo, 1x/yr)?

☐ Tobacco P C Frequency_____
☐ Alcohol P C Frequency_____
☐ Recreational Drugs P C Frequency_____
☐ Other P C Frequency_____

Please indicate whether or not the following applies:

a) Tattoos ☐ Yes ☐ No

b) Camping or out of country travel in the last year ☐ Yes ☐ No

If yes, where? _____

For Female Patients Only:

A Medical Assistant will be present during rectal exams. Do you also wish for a Medical Assistant to be present during heart/lung or palpation of the abdomen exams, etc. **Please indicate: Yes ☐ No ☐**

Date of last menstrual period: _____ Contraceptives used: _____

X _____ _____ _____

Signature of Patient or Personal Representative | Printed Name | Date

_____

Relationship to Patient

_____

Name of Patient (if different from signee)