

**COMPLIANCE ASSURANCE NOTIFICATION  
NOTICE OF PRIVACY PRACTICES  
HIPAA REGULATIONS**

To Our Valued Patients:

The misuse of personal health information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations, regarding the health insurance portability and accountability act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services to our patients.

It is our policy to properly determine appropriate use of (PHI) in accordance with the government rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI, as part of this plan, we have implemented a compliance program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Please take a moment to read the HIPAA posters that are in our office posted in several locations for your convenience. The posters provide information about your medical charts and how they may be used and disclosed, also how you can get access to this information. Please review them. This is material that is permitted or required by law, and describes your rights.

Thank you for being one of our highly valued patients.

Please sign this form so we may know you have seen our posters and understand. (This form will be placed in your chart).

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

**GI Consultants, LLC**

**Dr. Bhavin Dave**

**302-744-9310**

**ADVANCE BENEFICIARY NOTICE**

Beneficiary Notice

Medicare will only pay for services it determines to be “reasonable and necessary” under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Medicare program standards, Medicare will deny payment for that service. I believed that, in your case, Medicare is likely to deny payment for \_\_\_\_\_ for the following reasons:\_\_\_\_\_.

Beneficiary Agreement

I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature of Medicare Beneficiary:\_\_\_\_\_

Date:\_\_\_\_\_

**GI Consultants, LLC**  
**Bhavin Dave, MD**

Please complete the following questions to help us guide your treatment.

**Patient Name:**

**Date:**

**1. Current Gastrointestinal Problems (Circle all that apply)**

- ❖ Colon cancer screening
- ❖ History of polyps
- ❖ Abdominal pain
- ❖ Gas and Bloating
- ❖ Alternating Constipation and Diarrhea
- ❖ Constipation
- ❖ Diarrhea
- ❖ Nausea
- ❖ Vomiting
- ❖ Weight loss
- ❖ Black stools
- ❖ Blood in your stools
- ❖ Blood in the toilet bowl
- ❖ Blood on the tissue paper
- ❖ Anemia
- ❖ Heartburn/Reflux
- ❖ Difficulty swallowing/Food getting stuck
- ❖ Chest pain
- ❖ Abnormal liver tests
- ❖ Hepatitis C
- ❖ Abnormal Xray

**2. Other Symptoms (Circle all that apply):**

- |                                |                              |
|--------------------------------|------------------------------|
| Fever                          | Chills                       |
| Fatigue/Feeling tired          | Cough                        |
| Shortness of breath            | Swelling of legs             |
| Heart palpitations             | Chest pounding               |
| Back pain                      | Joint pain                   |
| Mouth sores                    | Skin rashes or lesions       |
| Blurred or double vision       | Ringing in ears/Hearing loss |
| Muscle weakness                | Numbness                     |
| Frequent headaches/Migraines   | Dizziness                    |
| Burning or pain with urination | Urinary accidents            |
| Anxiety                        | Depression                   |

**3. Your Medical History (Circle all that apply):**

- High blood pressure (even if on medication)
- High cholesterol (even if on medication)
- Congestive heart failure
- Heart Attack
- Bypass surgery
- Stent placement/Heart catheterization
- Heart murmur
- Mitral valve prolapse

- Asthma
- Bronchitis
- Emphysema
- COPD
- Pneumonia
- Tuberculosis

Diabetes:      Do you take                  Insulin                          Pills                          Diet controlled

- Thyroid problems
- Arthritis
- Seizures
- Depression
- Anxiety
- Stroke or Mini-strokes (TIA)
- Cancer (list what kind)

Have you ever been told you need antibiotics before any kind of dental procedure? YES NO

**4. List ALL of your medications below:**

**Do you have any allergies to any medications?**      Penicillin      Sulfa  
IV dye      Latex  
Other:

**Do you take any herbal medicines?**      Yes      No  
If yes, list them:

**Do you take any pain medicines?** (Circle all that apply)  
Motrin      Naproxen  
Advil      Celebrex  
Aleve      Other:

**Do you smoke cigarettes?**      Yes      No  
If yes, how much per day?    ¼ pack      ½ pack      1 pack      2 packs  
If you quit smoking, when did you quit?

**Do you drink alcohol?** (including beer, wine, and liquor)  
If yes, do you drink:    Rarely      Occasionally      Yes      No  
Weekends      Daily

**Do you use IV drugs?**      Yes      No      I quit

**Do you snort cocaine?**      Yes      No      I quit

**5. List ALL of your surgeries**

**6. Family History (Circle all that apply and list the relation of that person to you)**

Colon cancer      Breast cancer  
Colon polyps      Pancreatic cancer  
Liver cancer      Diabetes  
Heart disease      Other cancers:

PATIENT PROFILE

Doctor: Bhavin Dave, MD

PATIENT INFORMATION

EMAIL ADDRESS: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_  
Phone: \_\_\_\_\_ [ ] Home [ ] Work [ ] Other  
Phone: \_\_\_\_\_ [ ] Home [ ] Work [ ] Other

Sex: [ ] M [ ] F  
Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Marital Status: [ ] Single [ ] Married [ ] Divorced  
Referring Physician: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_

PATIENT EMPLOYMENT

CONTACTS

[ ] Employed [ ] Retired [ ] Other

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

GUARANTOR

EMPLOYMENT OF GUARANTOR

[ ] Same as patient

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_

Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other  
Insured Party: \_\_\_\_\_  
Insured Phone: \_\_\_\_\_  
Company: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID: \_\_\_\_\_

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other  
Insured Party: \_\_\_\_\_  
Insured Phone: \_\_\_\_\_  
Company: \_\_\_\_\_

Policy Group: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

I hereby authorize direct payment of surgical/medical benefits to GI Consultants, LLC for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize GI Consultants, LLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**GI Consultants, LLC**

**Dr. Bhavin Dave**

**302-744-9310**

**Important Billing and Insurance Information for our Valued Patients**

Thank you for selecting our practice for your gastrointestinal health. The following information is very important to receive coverage from your insurance company.

1. Your insurance company often requires a referral and/or a prior authorization from your Primary Care Physician. If your insurance company requires a referral or authorization you **WILL NEED** this **PRIOR** to your office visit with us. This is a policy which your insurance company has and we are required by your insurance company to obtain this number prior to seeing us. Anyone without a proper authorization will not be seen.
2. Many insurance policies have co-pays and/or deductibles which must be paid at the time of service. Once again, this is required by your insurance company.
3. Please know your insurance coverage in detail. Even the same insurance company offers several different policies with different coverage. For example, some Blue Cross plans require a referral for each specialist, office visit, and procedure; while other Blue Cross plans do not require a referral. These policies may change every year. So, please call your insurance company, workplace, or review your insurance handbook to have an understanding of your co-payments, deductibles, referral requirements, and where to go for special tests, such as xrays and bloodwork, to obtain the best coverage.
4. Please understand that our office calls your insurance company to get a prior authorization for a procedure based on your symptoms. However, this is not a guarantee of payment by your insurance company.
5. If your insurance company does not pay for your specialist visit or testing, **YOU** are responsible for that payment in a timely manner after reasonable efforts have been made to receive payment for your insurance company.
6. If you do not give 24 hours notice for canceling an appointment, you will be charged \$35 which will be your responsibility, not your insurance company.
7. You will be charged \$35 for any bounced check.

I acknowledge reading the above information.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_