Gastro Health Inc.

Kaunteya Reddy MD
264 N. Highland Springs Ave Ste 3B
Banning CA 92220
P: 909-488-4545 F: 909-435-0062

Appointment Date:_____ Check in by _____AM/PM

- Bring Insurance / ID
- Please have this packet completely filled out prior to coming to your appointment.

Date of Visit: _____

Patient Name: _____

Age: _____ DOB: _____ Gender: _____

SSN (Social Security Number): _____

Address: _____

Cell Phone: _____ Home Phone:_____

Emergency Contact Name and Number: _____

Referring Physician: _____

Reason For Visit: _____

Please List All Medical Conditions:

_____

_____

Primary Insurance: _____

Member/Subscriber ID: _____

Guarantor: _____

Secondary Insurance: _____

Member/Subscriber ID: _____

Guarantor: _____

Current Medication List

Name:_____ DOB:_____Date Last Updated:_____

NAME OF MEDICATION	STRENGTH & FREQUENCY	Condition Medication Taken For

Allergies:

_____

_____

Pharmacy Information:

Name: _____

Address: _____

Phone Number: _____

Please Answer The Following Questionnaire

1. Do you have or take medication for high blood pressure? Yes / No

2. Do you have or take medications for Diabetes? Yes / No

3. Do you have or take medications for Heart Disease? Yes / No

4. Do you have Sleep Apnea or use a CPAP Machine? Yes / No

5. Have you ever had a stroke? Yes / No

6. Do you smoke? Yes / No

7. Do you consume alcohol? Yes / No

8. Do you use Cannabis/ Marijuana? Yes / No

9. Have you ever had any surgeries? Yes / No

   If Yes please list: _____

_____

10. Have you ever had an Endoscopy or Colonoscopy? Yes / No

    If Yes which one or both? What Year? Doctor? _____

_____

11. Do you have a family history of Colon Cancer? Yes / No

12. Do you have a family history of Inflammatory Bowel Disease? Yes / No

13. Do you have an advanced directive? Yes / No

I hereby give consent for the examination, testing, and treatment by Gastro Health Inc. / Dr. Kaunteya Reddy. Please be aware that you may be responsible for reasonable attorney fees, court cost, collection costs, and interest at 1.5 % per month if your account becomes delinquent.

Patient Signature: _____Date: _____

Gastro Health Inc.

REVIEW OF SYSTEMS (PLEASE CIRCLE) :

GENERAL/ CONSTITUTIONAL: Fever, Fatigue, Weakness, Weight Gain/Weight Loss

ENT: EYES-pain, redness, dryness, loss of vision, double or blurred vision, **EARS:** Ringing in the ears, loss of hearing, **NOSE:** Frequent nose bleeds, loss of sense of smell, sinusitis, post nasal drip, **MOUTH:** Sore tongue, bleeding gums, sores in the mouth, loss of sense of taste, dry mouth, throat-frequent sore throats, hoarseness or constant feeling of a need to clear throat, difficulty swallowing, and/or pain with swallowing.

CARDIOVASCULAR: Chest pain, palpitations, shortness of breath, difficulty breathing at night, swollen legs or feet, heart murmurs, High Blood Pressure.

RESPIRATORY: Dry cough, coughing up blood, coughing up mucus, waking up in the night coughing or choking.

GASTROINTESTINAL: Decreased appetite, nausea, vomiting, vomiting up blood or coffee ground material, Heartburn, regurgitation, frequent belching, abdominal pain, trouble swallowing, jaundice, diarrhea, constipation, gas, bloating, blood in stools, black tarry stools, and/ or hemorrhoids.

GENITOURINARY: Difficulty urinating, pain or burning with urination, blood in the urine, frequent need to urinate, urgency, needing to urinate frequently at night, inability to hold the urine.

MUSCULOSKELETAL: Muscle cramps, joint or muscle pain, muscle weakness or tenderness, joint swelling, neck pain, and or back pain.

SKIN: Easy bruising, skin redness, skin rash, hives, sensitivity to sun exposure, hair loss, color changes in the hands and feet with cold.

NEUROLOGY: Frequent headaches, dizziness, fainting, muscle spasms, loss of consciousness or memory loss.

PSYCHIATRY: Depression, anxiety, nervousness, sleep problems.

ENDOCRINOLOGY: Intolerance to hot or cold temperatures, flushing, increased thirst.

HEMATOLOGIC/LYMPHATIC: Anemia, bleeding tendency or clotting tendency.

ALLERGY/IMMUNOLOGY: Rhinitis, asthma, skin sensitivity or food allergies.

PATIENT SIGNATURE: _____ DATE OF VISIT: _____

GASTRO HEALTH INC

Kaunteya Reddy M.D.

SMS Text Message Consent Form

Gastro Health Inc would like to offer you the ability to receive text message reminders for your appointments booked at one of our locations. While we don't charge for this service, you may incur charges from your carrier for receiving the text message.

Please check the box below

☐ I CONSENT to the practice contacting me by text message for the purpose of appointment reminders. **I will ensure that I keep the practice informed of my up to date mobile number at all times, or if the number is no longer in my possession.**

Patient Name: _____

Date of Birth: _____

Mobile Number: _____

Signature: _____

Today's Date: _____

We will not send any text unless you have explicitly consented to receive them.

Practice Use Only: SMS CONSENT TEMPLATE COMPLETED

FORWARD FOR SCANNING STAFF INITIALS_____

26021 Business Center Dr. Redlands CA 92374
264 N. Highland Springs Ave Ste B Banning CA 92220
22635 Alessandro Blvd Suite B Moreno Valley CA 92553

NOTICE OF PRIVACY PRACTICE

This practice is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information:

1. We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or health care operations.
2. We may disclose your health information to your insurance provider for the purpose of payment and healthcare options.
3. We may disclose your health information as necessary to comply with State Workers Compensation Laws.
4. We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition, or in the event of an emergency or of your death.
5. As required by law, We may disclose your health information to public health authorities for the purpose related to: Preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
6. We may disclose your health information in the course of any administrative or judicial proceeding.
7. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
8. We may disclose your health information to coroners or medical examiners.
9. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs or tissues.
10. We may disclose your health information researchers conducting research that has been approved by an Institutional Review Board.
11. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public
12. We may disclose your health information for military, national security, prisoner and government benefit purposes.
13. We may contact you for the purpose of making an appointment of reminding you of an existing appointment. If you are not home we may leave a reminder message on your answering machine or voicemail or with a person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment or a request to call us so that an appointment can be made
14. in the event that this practice is sold or merged with another organization, your health information / record will become the property of the new owner.

Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is nor required to agree to the restriction that you requested
2. You have the right to have your health information received of communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery; upon your request.
3. You have the right to inspect and copy your health information.
4. You have the right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend you protected health information. If you request to amend your health information is denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
5. You have the right to receive an accounting of disclosures of your protected health information made by this practice.
6. You have the right to a paper copy of this Notice of Privacy Practices at any time upon requested.

Changes to this Notice of Privacy Practices
This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this notice.

This practice is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Privacy Officer by calling this office.

Complaints
Complaints about your Privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201

This notice is effective as of the date shown below. I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purpose of treatment payment and health care operations as described in the Privacy Notice.

_____
Patient Name

_____ _____
Patients Signature Date

_____ _____
Authorized Facility Signature Date

Gastro Health Inc
Kaunteya Reddy MD

Patient's Medicare Authorization

Patient Name: _____

Patient's Medicare Number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to:

_____

For any services furnished me by that physicians/supplier. I authorized any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine this benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 Form, or elsewhere on other approved claim forms of electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. On Medicare assigned cases, the physician or supplier agrees to accept the change determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and no covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____
(PATIENT SIGNATURE) (DATE)

MEDIGAP AUTHORIZATION

(Fill out if you have Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare supplement policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain cost that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.)

Patients Name: _____

Medigap Policy No:_____

I request that paymet of authorized MEDIGAP benefits be made either to me or on my behalf to:

_____
(Participating Physician or Supplier)

For services furnished by me by that participating physician/supplier. I authorized any holder or hospital or medical information about me to be release to

_____
(Medigap Insurance Company)

_____
(Address of Claims Processing)

Any information needed to determine these benefits payable for related services, I permit a copy of this authorization to be used in place of the original. This authorization is in force until it is either cancelled or changed by me.

_____
(PATIENT SIGNATURE) (DATE)

Name_____ Medicare # _____
(PLEASE PRINT) (IF APPLICABLE)

Signature on File

( ) I authorize use of this form on all my insurance submissions
( ) I authorize release of information to all my insurance companies.
( ) I understand I am responsible for my bill
( ) I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
( ) I authorize payment directly to my doctor.
( ) I permit a copy of this authorization to be use in place of the original.

Signature _____ Date _____