GI Excellence, Inc.

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PATIENT INFORMATION/OFFICE POLICY AND PROCEDURE

It is customary for our offi ce to update this information every six months or as we feel necessary when changes are made.

PATIENT NAME ____ MARITAL STATUS S M W D SEP

DATE OF BIRTH _______/________/________S.S. # __________________________ DRIVERS LIC # ___________________________________

ADDRESS____CITY ________________________STATE ______ZIP__________________

EMAIL ADDRESS: ____

HOME PHONE (________) _____________ WORK PHONE (________) _____________ CELL PHONE (________) _____________

All that applies: **Authorized Methods of Communication**

HOME NUMBER

( ) Leave call back number only

( ) Ok to leave a detailed message with person

( ) Ok to leave detailed message on voicemail

WORK NUMBER

( ) Leave call back number only

( ) Ok to leave a detailed message with person

( ) OK to leave detailed message on voicemail

CELL PHONE

( ) Leave call back number only

( ) Ok to leave detailed voicemail

EMPLOYER NAME AND ADDRESS ____

SPOUSE'S NAME _____________________________ DATE OF BIRTH_______/________/________SS #___________________________________

EMERGENCY____________________________ PHONE (________) _____________ RELATIONSHIP___________________________________

CONTACT (other than spouse) ADDRESS ____

Do we have your permission to discuss your medical conditions with anyone other than you? __YES __NO

If yes: Name ____Relationship ____

WHO IS YOUR PRIMARY CARE DOCTOR? ____

WHO IS REFERRING YOU TO OUR OFFICE? ____

DO YOU HAVE AN ADVANCED DIRECTIVE? ( ) YES ( ) NO

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions on your own. If you already have an advanced directive we encourage you to provide us with a copy at your next visit. If you don't have an advanced directive and would like more information regarding one, please visit www.advancedirectivellc.com

OFFICE POLICIES

PLEASE READ! YOUR SIGNATURE AT THE END OF THESE FORMS ASSURES US THAT YOU HAVE READ AND UNDERSTAND ALL THAT IS STATED.

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You will be asked for your insurance card(s). A copy will be kept in your fi le and is strictly confi dential. We consider your bill to be part of your medical treatment. If you have not provided us with the appropriate information to bill your insurance and do not keep us updated on any changes, you will be considered a CASH patient and services will be due in full each time you are treated. Your insurance policy is a contract between you and your insurance company.

We are NOT party to that contract and will not be able to resolve any issues you may have with your insurance co. It is your responsibility to know what your insurance will or will not cover, if you have a deductible, how much the deductible is or what you have or have not met of your deductible. If you are provided services based on being a Medicare/Pvt.Ins.

If medical services are denied because you are covered by an HMO/Other Ins., or not covered at all, you will be responsible for payment in full to our offi ce. You agree to pay within 30 days of receiving a bill and understand that we will NOT request prior auth from the HMO or other Ins. for services already rendered. We have the right to refuse service for any unpaid balances or unsolved insurance issues. Co-payments and/or deductibles are to be paid prior to seeing the doctor. If you do not have the money to pay as requested, your appointment will be rescheduled.

Our offi ce does not accept CHECKS for co-payments which are due before seeing the doctor. Please come prepared each time with CASH or CREDIT CARD for your co-payment amounts.

**ALL PATIENTS are required to know their insurance benefi ts, coverage and participating provider eligibility. Our offi ce will not confi rm that information for you. Please call your insurance company directly!

PRIVATE INSURANCE: As a courtesy we will bill your ins. co. for you one time. You must provide us with the necessary billing information and the address to the ins. co. It is your responsibility to know if Dr. Chakrabarty and/or Hemet Endoscopy Center are providers for your ins. It is also your responsibility to know what outside facilities (lab, x-ray, etc.) your insurance authorizes you to use. If you do not inform us IN ADVANCE, we will use the facility of OUR choice. Services deemed "non-covered" or not considered "reasonable" and "necessary" by your ins. co. will automatically become your responsibility. If your ins. co. has not paid or denied your claim within 60 days, the balance will be transferred to you and must be paid within 30 days. If your bill with our offi ce is deemed a non-covered service by your insurance company, you will be responsible for the balance in full.

MEDICARE PATIENT: We are a participating provider under the Medicare program and accept assignment. If you have a 2nd insurance, we will bill that insurance for you as well. Deductible amounts may be requested from you at the time of service. Services deemed "noncovered" or considered "reasonable" and "necessary" by your insurance will automatically become your responsibility, in full.

HMO PATIENT: You will be asked for your co-payment before seeing the doctor. If your HMO denies services because you were not eligible, the bill will be your responsibility. We will NOT request retroactive auth for services. If you are not prepared to pay your copayment at the time of your appointment, we will need to reschedule for a later date.

MEDICAID: We will need to run your card, prior to seeing the doctor. If you have a share of cost you will need to pay that amount before the doctor will see you. If you do not have the payment available we will need to reschedule for a later date.

MISSED APPTS: Unless canceled 24 hours in advance, you will be charged a rate of $80. If you fail to keep appointments we will not continue to refi ll your medications.

RETURNED CHECKS: A service charge of $30.00 will be charged for each time the check is returned.

LETTERS/FORMS/MISC FEE: Due to the time it takes the doctor and staff to prepare letters, complete forms, or provide information often requested by patients or various agencies, there will be a charge for each request. (Minimum $35.00) Payment must be made in advance and cannot be billed to your insurance company. These requests take time to complete. Please allow our offi ce 5-10 working days to process requests. We will call you when it is ready for pickup. To insure proper delivery, we are unable to mail your requests..

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PRESCRIPTION REFILLS: We MUST have 24 hours (business hours) to process your request for refi lls by phone/fax. Written requests may take 3-5 working days. To insure proper delivery we cannot mail your prescriptions. Please do not allow yourself to completely run out of your medications.

MEDICAL RECORDS: Your medical records become a permanent part of your fi le in this offi ce. We cannot reproduce copies of photos or videos, but we will be happy to reproduce copies of records of Dr. Chakrabarty and/or Hemet Endoscopy Center. We do not provide free copying services. Upon your written and signed request or that of your legal representative (proof will be required), we will process your request within 15 days. There will be a minimum charge of $25. Depending on the size of your chart, the fee may be more.

RECEIPTS: If you will need receipts of your payments, please ask! You must make this request at the time payment is made. A charge of $30 will apply if we have to produce this information for you at a later time.

LAB/X-RAY RESULTS: Due to the new "Privacy Rules" established by the Department of Health and Human Services, it becomes difficult for us to verify your identity over the phone. Therefore, it is not customary for our offi ce to call you with your results unless there is a severe abnormality. If there is nothing life threatening with your results they will be discussed with you at your next office visit.

FAMILY REQUEST: We often receive calls from concerned family members or neighbors. Due to the new "Privacy Rules" established by the Department of Health and Human Services, we can NOT give out ANY information to anyone not authorized with a legal document. Please notify your spouse, children, etc., to not call our offi ce requesting information about you. We WILL NOT are allowed to answer their questions. We encourage those involved in your care to attend your scheduled appointments with you.

COLLECTION PROCEDURE: If it becomes necessary for our offi ce to use a collection agency to collect on your account, a charge of 35% of your total account balance will be applied and will be your responsibility. Please communicate with our offi ce regularly regarding your account status to avoid unnecessary proceedings.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of surgical/medical benefi ts to Milan S. Chakrabarty, M.D., Inc./GI Excellence/Hemet Endoscopy Center. I understand that I am fi nancially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Milan S. Chakrabarty, M.D, Inc./GI Excellence to release any medical or incidental information that may be necessary for either medical care or in processing application for fi nancial benefi t. MEDICARE/ MEDICAID: 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 benefi ts be made on my behalf.

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL WAIVER: If you are scheduled now or will be scheduled in the future for any of the following: ROUTINE/ANNUAL PHYSICAL, DMV PHYSICALS, INJECTIONS, please be advised that your insurance (Medicare if applicable) MAY NOT COVER these services, or your annual physical if billed as such. In the event that services are not covered you will be responsible for the full charge. If your insurance will pay for the above care, please advise YOUR PHYSICIAN the day of your appointment. This will allow the physician to code your service in accordance with your insurance coverage. If you fail to do so, we will not be able to alter your diagnosis or re-bill the insurance company.

MEDICAL CONSENT FOR TREATMENT/EVALUATION: The undersigned consents to any x-ray, anesthesia, medical, diagnosis, laboratory procedures, medical and surgical treatment or hospital services rendered to the patient signed below, under the general or special supervision of, or upon the advice of any physician employed by GI Excellence, Inc. IMPORTANT, please note: If a patient is a minor, the parent having legal custody, a legal guardian, or a person authorized by them in writing, must sign. If a patient is incompetent, a legal guardian or conservator must sign.

PATIENT CONSENT FORM: The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

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As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. A complete description of the HIPAA notice of privacy practices is attached for your review. A photocopy is also available if requested.

Your signature at the end of these forms acknowledges that you have read and/or received a copy of this "Privacy Rule". You also acknowledge that a copy of the current notice is posted in our reception area.

By signing below you agree that you have provided our offi ce with complete and accurate patient, insurance, and medical history information.

You have read and understand all the forms enclosed: (pages 1-4)

- OFFICE POLICIES
- PATIENT CONSENT FORM FOR THE PRIVACY RULE
- THE ASSIGNMENT OF BENEFITS
- ADVANCE DIRECTIVE INFORMATION

NOTICE TO CONSUMERS: Medical Doctors are licensed & regulated by the Medical Board of CA, 800-633-2322. Thank you for choosing us as your health care provider. All patients must complete and sign these forms before seeing the doctor. You may be asked to update this information annually or as necessary. Our offi ce has allowed you plenty of time to read and ask any questions that you may have. If you would like a copy of these forms please ask the receptionist.

Patient Signature (or legal guardian): ____ Date ______________________