UNITED
GASTROENTEROLOGISTS

GARY M. ANNUNZIATA, D.O., F.A.C.P. / ANH T. DUONG, M.D. / NATALIE SLOAN, FNP-C.
MEGAN LANCASTER FNP-C / ALEX MONTEIRO FNP-C
35900 Bob Hope Drive, Suite #275. Rancho Mirage, Ca. 92270 / PH: 760-321-2500 / FX: 760-321-5720

PATIENT INFORMATION

Patient Name: _____ **Sex: M____F____**

D.O.B: _____ **Race:** _____ **Ethnicity:**_____

Social Security#: _____ **Marital Status**_____

Address: _____

City/State: _____ **Zip Code:** _____

Home Phone: _____ **Cell:** _____

Order preference to contact you? Please list below

1. _____ **Morning Afternoon Evening Anytime**
2. _____ **Morning Afternoon Evening Anytime**

Emergency Contact_____**Phone:**_____

Employer Name: _____**Phone:**_____

Employer Address: _____**Zip:**_____

Primary Care Physician: _____**Phone:**_____

Primary Insurance Information

Insurance Company: _____

Policy #:_____ **Group #:** _____

Policy holder: _____ **Relationship to holder:** _____

Secondary Insurance Information

Insurance Company: _____

Policy #:_____ **Group #:** _____

Policy holder: _____ **Relationship to holder:** _____

Interested in receiving our newsletter? YES_____ NO_____

Let us know whether you'd like to receive our:
_____Newsletter
_____Healthcare Updates
_____Both, via email

Email Address: _____

Patient Signature: _____ **Date:** _____

DESERT GASTROENTEROLOGY CONSULTANTS
GARY M. ANNUNZIATA, D.O., F.A.C.P. / ANH T. DUONG, M.D. / NATALIE SLOAN, FNP-C.
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FINANCIAL RESPONSIBILITY

On occasion your insurance may determine the care you have received is NOT a covered benefit. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt contact your insurance company directly for clarification. You will be responsible for care not covered by your insurance plan.

- **Not a Covered Benefit – is not covered or only partially covered by your insurance plan, also excluded may be work injury or auto accidents.**
- **Not deemed medically necessary – not provided as the result of illness or injury.**
- **Before or after Eligibility- services provided during a period your policy is not in effect.**

AUTHORIZATION TO RELEASE INFORMATION- I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. (If other health insurance coverage is indicated in ITEM 9 of the HCFA 1500 claim form or elsewhere on other approved claims forms or electronically claims, my signature authorizes releasing the information to the insurer or agency shown.

MEDICARE BENEFIT ASSIGNMENT - I request that a payment of authorized Medicare benefits be paid either to me or on my behalf of Gary M. Annunziata, D.O., F.A.C.P./Anh T. Duong, M.D. / Natalie Sloan, FNP-C. / Megan Lancaster, FNP-C / Alex Monteiro, FNP-C for any services furnished to me by these physicians or supplier. I authorize any holder of medical information about me be released to the healthcare financing administration and its agents; any information needed to determine these benefits payables to related services.

Financial Authorization - I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also hereby authorize the physician to release any information required to my insurance in order to process this or any future medical claims with this office.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY FINANCIAL OBLIGATION TO DR. ANNUNZIATA, DR. DUONG, NATALIE SLOAN, FNP-C, OR MEGAN LANCASTER, FNP-C. / ALEX MONTEIRO, FNP-C.

PATIENT NAME	**PATIENT SIGNATURE**	**Date**

DESERT GASTROENTEROLOGY CONSULTANTS
GARY M. ANNUNZIATA, D.O., F.A.C.P. / ANH T. DUONG, M.D. / NATALIE SLOAN, FNP-C. / MEGAN LANCASTER FNP-C / ALEX MONTEIRO, FNP-C

OUR OFFICE POLICY

In response to the complex healthcare industry, we have taken steps to optimize our operations in order to spend more time on patient care and less time on administration. This will require your help. Please carefully read the items below as they will be strictly enforced. Our goal is to provide high quality, compassionate and timely healthcare.

1. Our office practices a Physician-Patient Arbitration Agreement. In order to be a patient in this practice, the arbitration contract must be signed.

2. Co-payments, Deductibles, and Co-Insurance are due at the time of service.

3. There is an additional charge for all forms, medical records and administrative requests.

4. There will be a $25.00 charge on all returned checks.

5. As a courtesy to the physician or other patients, we ask that you call at least 24 hours in advance to cancel or reschedule your office visit or procedure.

6. All pharmacy refill requests should be done by you calling your pharmacy and asking them to fax our office a refill notice. There will be no weekend refills.

7. You must update us with new address, telephone numbers and insurance as soon as possible.

8. We realize that your appointment may be several weeks after your test is complete. We ask that you call our office if you would like to know the results of any tests prior to your next office visit. The purpose of your follow up office visit is to review the results of a test, pending records, or to follow up on a chronic or unresolved problem. Failure to comply with this may result in delay of diagnosis, treatment prolonged illness or death. We ask that you never assume that your tests are negative if the office has not called you.

9. Please understand our office policy of NOT allowing an established patient to switch to another physician within this practice.

10. If you are advised to go to the Emergency Room by a physician or representative, you must do so. Failure to comply may result in delay of diagnosis, treatment, prolonged illness, or death

I HAVE READ THE ABOVE INFORMATION AND AGREED TO FOLLOW THE ABOVE-MENTIONED GUIDELINES.

_____	_____	_____
Patient Name- Please Print	Patient Signature	Date

DESERT GASTROENTEROLOGY CONSULTANTS
GARY M. ANNUNZIATA, D.O., F.A.C.P. / ANH T. DUONG, M.D. / NATALIE SLOAN, FNP-C.
MEGAN LANCASTER FNP-C / ALEX MONTEIRO FNP-C

HIPAA Release Form

Name: _____ DOB: _____

- ❑ I authorize the release of information including the diagnoses, records; examination rendered to be and claims information.

This information may be released to:

- ❑ Spouse:_____ Phone Number: _____
- ❑ Child(ren):_____Phone Number: _____
- ❑ Other:_____ Phone Number: _____

- ❑ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Acknowledgment of Receipt of Notice of Privacy Practice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

If not signed by the patient, please indicate.
Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Signature: _____

For office use only:
Signed form received by: _____

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C**

I understand that diagnosis or treatment of me by **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D./ Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C** is not required to agree to the restrictions that may request however, if **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D./ Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C** agrees to a restriction that I request, the restriction is binding on **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D./ Natalie Sloan, FNP-C / Megan Lancaster FNP-C/ Alex Monteiro, FNP-C**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D./ Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C/ Alex Monteiro, FNP-C** Notice of Privacy Practices prior to signing this document.

The **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C**

The Notice of Privacy Practices for **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C/ Alex Monteiro, FNP-C** is also posted on the wall in the break room.

This Notice of Privacy Practices also describes my rights and the duties of **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C** with respect to my protected health information.

Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the **Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D./ Natalie Sloan, FNP-C / Megan Lancaster FNP-C / Alex Monteiro, FNP-C** by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____
Signature of Patient or Personal Representative	Name of Patient or Personal Representative
_____	_____
Date	Description of Personal Representative's Authority