Desert Gastroenterology Consultants

The office of:

Dr. Gary M. Annunziata / Dr. Anh T. Duong
Dr. Jonathan C. Lin / Dr. Adewale B Ajumobi / Natalie Sloan FNP
35900 Bob Hope Drive, Ste. 275
Rancho Mirage, CA. 92270
Telephone- (760) 321-2500
Fax- (760) 321-5720

The office is located on Bob Hope Drive between Gerald Ford and Dinah Shore in the Rancho Mirage Professional Plaza.

Patient Name- _____

Appointment Date- _____

Appointment Check-in Time- _____

Appointment Time- _____

Welcome to our office!!

Enclosed you will find our new patient paperwork. We hope you find your experience with our office a pleasant one. Enclosed you will find the following forms that need to be completed PRIOR TO your scheduled appointment.

1. **Patient information sheet (please fill out completely)**
2. **Insurance Contract**
3. **Medicare Authorization To Bill**
4. **If applicable, Screening ABN's for a Colonoscopy**
5. **Office Policy**
6. **Patient Medication List (fill out completely, dosage and directions)**
7. **Health History Questionnaire (2pages front and back, total of 4)**
8. **Other- _____**

Please fill out these forms completely and mail or fax to (760) 321-5720 or bring them to our office PRIOR to your appointment.

In addition, please bring in your insurance cards and a photo ID. Please double check your insurance card(s) and make sure your member ID and the claims mailing address are legible, if not please contact your insurance carrier for the correct information.

We appreciate your cooperation. If you have any questions, please contact our office.

Sincerely,
Desert Gastroenterology Consultants

Website:

If you would like additional information about our office, we would ask that you visit our website at: www.desertgastro.net

DESERT GASTROENTEROLOGY CONSULTANTS

GARY M. ANNUNZIATA, D.O. / ANH T. DUONG, M.D. /
JONATHAN C. LIN, M.D. / ADEWALE B. AJUMOBI M.D / NATALIE SLOAN, FNP

PATIENT INFORMATION

GOVERNMENT REQUIREMENT FOR ELECTRONIC HEALTH CARE REPORTING

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER_____

RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALAKA NATIVE
☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ DECLINE

ETHINICITY: ☐ HISPANIC/LATINO ☐ NON-HISPANIC/LATINO ☐ DECLINE

PATIENT NAME: _____ BIRTHDATE _____ AGE _____
FIRST MIDDLE LAST

PERSON LEGALLY RESPONSIBLE
(IF PATIENT IS A MINOR, NAME OF PARENT/GUARDIAN) _____

PERMANENT MAILING ADDRESS : _____
STREET CITY ZIP HOME PHONE

LOCAL ADDRESS: _____
(IF DIFFERENT FROM ABOVE) STREET CITY ZIP CELL PHONE

SOCIAL SECURITY NO.: _____ DRIVERS LICENSE NO.: _____

STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW(ER) ☐ DOMESTIC PARTNER

PATIENTS EMPLOYER: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____
STREET CITY ZIP WORK PHONE

EMERGENCY CONTACT

NAME: _____RELATIONSHIP:_____PHONE:_____

INSURANCE INFORMATION

PRIMARY INS. _____ NAME OF INSURED _____

SECONDARY INS. _____ NAME OF INSURED _____

PHYSICIAN INFORMATION

REFERRING PHYSICIAN _____

PRIMARY CARE PHYSICIAN_____

SIGNATURE_____

35-900 BOB HOPE DRIVE SUITE #275, RANCHO MIRAGE, CA. 92270
PHONE (760) 321-2500 FAX (760) 321-5720

Desert Gastroenterology Consultants

The office of:

Gary M. Annunziata, D.O., FACP / Anh T. Duong, M.D.
Jonathan C. Lin, M.D., MPH / Adewale B. Ajumobi, MD MBA, FACP / Natalie Sloan, FNP

Please note the following are a list of primary insurance companies that Dr. Annunziata, Dr. Duong and Dr. Lin contracted with:

- **Medicare**
- **Blue Cross**
- **Blue Cross Select Plan – *Dr. Duong Only.***
- **Blue Shield**
- **Keenan and Associates**
- **United HealthCare**
- **PacifiCare**
- **Triwest Prime- with authorized referral**
- **Triwest/Tricare**
- **4 Your Choice**
- **Aetna**
- **HealthNet**
- **Kaiser – *Dr. Lin Only.***

For insurance questions regarding Dr. Ajumobi and Natalie Sloan FNP please contact the office.

Blue Cross Covered California and Blue Cross Exchange Plans please contact the office to make sure your doctor is contracted with your specific plan.

If you have insurance coverage with another company that is not listed above, we will bill your insurance company on your behalf, but we ask that you contact your insurance company to obtain any deductible and co-pay information for seeing a provider OUT OF NETWORK.

If you have any questions, contact the office at (760) 321-2500.

By signing below you have read and understood the above.

_____ _____

Patient Name- Please Print **Date**

_____

Patient's Signature

Desert Gastroenterology Consultants

The office of:
Gary M. Annunziata, D.O., FACP / Anh T. Duong, M.D.
Jonathan C. Lin, M.D., MPH / Adewale B. Ajumobi, MD MBA, FACP / Natalie Sloan, FNP

35900 Bob Hope Drive, Ste. 275 Rancho Mirage, CA. 92270
Phone- (760) 321-2500 Fax- (760) 321-5720

Patient Name- _____

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. / Jonathan C. Lin, M.D. / Adewale B. Ajumobi M.D. / Natalie Sloan, FNP. 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 payable to related services.

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 claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient Signature **Date**

A. Notifier: Desert Gastroenterology Consultants
Dr. Annunziata, Dr. Duong, Dr. Lin, Dr. Ajumobi, and Natalie Sloan FNP-C.
35-900 Bob Hope Dr. Ste 275, Rancho Mirage, CA 92270 760-321-2500

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
New or established office visit for: 99202-99213 Sreening purpose of colon cancer Z12.11 OR Screeening purpose due to Family HX of colon cancer Z80.0	**Screening Medicare office visit** **Medicare WILL NOT pay for an office visit for screening purposes only**	**$125.00**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understood this notice. You also receive a copy.

I. Signature:	J. Date:

Gary M. Annunziata, D.O., F.A.C.P.
Anh T. Duong, M.D.
Jonathan C. Lin, M.D., MPH
Adewale B. Ajumobi, M.D
Natalie Sloan, FNP.

Dear Patient,

You have been scheduled for an office visit (99202/99213) with Dr. Annunziata, Dr. Duong, Dr. Lin, Dr. Ajumobi or Natalie Sloan FNP-C,
on _____ at _____.
Enclosed are our new patient information forms. Medicare has notified us that the initial office visit (99202/99213) that is required for a screening (Z12.11) colonoscopy is **NOT** a covered benefit. There are two types of screening exams:

- Screening purpose of colon cancer
- Screening purpose due to family history of colon cancer

Therefore, payment will be required at the time of service for the initial office visit ($125.00). We ask that you please sign and date the bottom portion of this notice and return it along with the other forms to our office.

If you should have any questions, contact the office at 760-321-2500.

Sincerely,
Office Staff

I have read and understood the above and wish to proceed with the initial office visit (99202/99213) for a screening (Z12.11) colonoscopy.

_____ _____
Signature Print Name

_____
Date

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. ***Know your insurance plan and what your benefits are*. Many visits may not be covered. It is your responsibility to understand your insurance coverage and benefits. If we are not contracted provider with your insurance plan you will incur higher out-of-pocket expenses.**

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

4. **There is an <u>additional charge</u> for all forms, medical records and administrative requests.**

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

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.**

9. **Due to the volume of tests, we are unable to call results to every patient. If you would like to know your results or are unable to be at your appointment, <u>IT IS YOUR RESPONSIBILITY</u> to call the office. We ask that you <u>never</u> assume that your tests are negative if the office has not called you.**

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

11. **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**

12. **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 and agreed to follow the above-mentioned guidelines and by signing below I acknowledge receiving a copy of this.

_____	_____	_____
Patient Name- Please Print	**Patient/or Guardian Signature**	**Date**

Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D. / Jonathan C. Lin, M.D. / Adewale B. Ajumobi M.D. / Natalie Sloan, FNP.
<u>35-900 Bob Hope Drive Suite# 275, Rancho Mirage, CA 92270</u>
Phone- (760) 321-2500 Fax- (760) 321-5720

Patient Name-_____Date of Birth-_____

Please complete the following medication and drug allergy form. Include medication name, strength, and how often you take it. If you require additional space please use a separate sheet of paper or write on the back of this form.

MEDICATION NAME:	STRENGTH :	HOW MANY TIMES A DAY:

ALLERGIES (Please include medication name and type of allergic reaction you experience):

_____

_____

_____

_____

HEALTH HISTORY

GARY M. ANNUNZIATA, D.O., F.A.C.P. / ANH T. DUONG, M.D.
JONATHAN C. LIN, M.D., MPH / ADEWALE B. AJUMOBI, M.D / NATALIE SLOAN, FNP.

PATIENT NAME- _____ D.O.B._____

To help us meet all of your needs, please fill out both sides of this form completely in ink. This is a confidential record of all your medical history and will be kept in this office.

Today's Date- _____

Place of Birth-_____

Highest level in School- _____

Primary Care Physician- _____

Occupation-_____

Reason for appointment today/Chief Complaint

_____
_____
_____

Hospitalization or Surgery—Please indicate date and reason

_____
_____
_____
_____
_____
_____
_____
_____
_____

Habits

Smoking (amount per week) _____ ***If former smoker, date quit _____***

Alcohol (type & amount per week) _____ ***Caffeine (type & amount per day) _____***

Street Drugs (type & amount per day) _____

Family History- please fill in as much information as possible- please check box if diagnosis applies:

Diagnosis	Father Age at death_____ Cause of Death: _____	Mother Age at Death_____ Cause of death: _____	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
Hypertension						
Stroke						
Cancer (type): _____						
Colon Cancer/ Colon polyps						
Ulcerative Colitis/ Crohn's Disease						
Diabetes						
Liver Disease						

Past Medical History- please check all that apply to you:

__ Scarlet Fever	__ Rheumatic Fever	__ Allergies/Hay fever	__ Diabetes	__ Alcoholism
__ Fatigue	__ Thyroid disease	__ Dizziness/Fainting	__ Shortness of Breath	__ Asthma
__ COPD	__ Congenital Heart Ds.	__ Chest pain/Angina	__MI	__ Hepatitis _____
__ Heart Palpitations	__ Arrhythmia	__ CHF	__ Heart Murmur	__ Hypertension
__ High Cholesterol	__ Blood clots/DVT	__ Esophageal stricture	__ Ulcer	__ Liver disease
__ Colon polyps	__ Mitral valve prolapse	__ Renal disease	__ Sexual dysfunction	__ Menstrual dysfunction
__ Venereal Disease	__ Arthritis	__ Gout	__ Stroke/TIA's	__ Epilepsy
__ Anxiety	__ Anemia	__ Endocrine Disease	__ Blood transfusion	
__ Cancer_____				

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any change in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary healthcare services I (my child) may need.

X _____ _____ _____

Signature of patient /or parent of minor **Date** **Physician's Signature**

Review of Systems (Please check all that apply to you)

SKIN

- ❑ **Color changes**
- ❑ **Dryness**
- ❑ **Easy Bruising**
- ❑ **Hair loss**
- ❑ **Infection**
- ❑ **Itching**
- ❑ **Nail Problem**
- ❑ **Rashes**
- ❑ **Sores**
- ❑ **Squamous cell cancer**

EYES

- ❑ **Blurred vision**
- ❑ **Burning**
- ❑ **Cataracts**
- ❑ **Contacts**
- ❑ **Discharge**
- ❑ **Dryness**
- ❑ **Glaucoma**
- ❑ **Itching**
- ❑ **Pain**
- ❑ **Photophobia**
- ❑ **Redness**
- ❑ **Sclera**
- ❑ **Swelling**
- ❑ **Tearing**
- ❑ **Visual changes**

HEAD/EAR/NOSE/THROAT/MOUTH/NECK

- ❑ **Deafness**
- ❑ **Discharge**
- ❑ **Dizziness**
- ❑ **Headaches**
- ❑ **Hoarseness**
- ❑ **Loss of smell**
- ❑ **Nose Bleed**
- ❑ **Post nasal drip**
- ❑ **Sinusitis**
- ❑ **Sore throat**
- ❑ **Tinnitus**
- ❑ **Vertigo**

CARDIAC/RESPIRATORY

- ❑ **Bronchitis**
- ❑ **Chest pain**
- ❑ **Cough**
- ❑ **Coughed blood**
- ❑ **Dyspnea**
- ❑ **Hemopytosis**
- ❑ **Mitral valve prolapse history**
- ❑ **Murmurs**
- ❑ **Nocturia**
- ❑ **Orthopnea**
- ❑ **Palpitations**
- ❑ **Phlegm**
- ❑ **Pleuretic chest pain**
- ❑ **Shortness of breath**
- ❑ **Sputum**
- ❑ **Wheezing**

GASTROINTESTINAL

- ❑ **Abdominal distention**
- ❑ **Abdominal pain**
- ❑ **Alternating constipation/diarrhea**
- ❑ **Appetite loss**
- ❑ **Belching**
- ❑ **Black tarry stools**
- ❑ **Colon polyps**
- ❑ **Constipation**
- ❑ **Diarrhea**
- ❑ **Dysphagia**
- ❑ **Food intolerance**
- ❑ **Gaseousness**
- ❑ **Heartburn**
- ❑ **Hemorrhoids**
- ❑ **Hepatitis, Type _____**
- ❑ **Hernias**
- ❑ **Indigestion**
- ❑ **Jaundice**
- ❑ **Nausea**
- ❑ **Poor appetite**
- ❑ **Rectal bleeding**
- ❑ **Regurgitation**
- ❑ **Vomiting**

GENITOURINARY

- ❑ Bloody urine
- ❑ Cloudy Urine
- ❑ Dark urine
- ❑ Dribbling
- ❑ Dysuria
- ❑ Flank pain
- ❑ Frequency of urination
- ❑ Hesitancy
- ❑ History of UTI's
- ❑ HPV
- ❑ Impotence
- ❑ Incontinent of urine
- ❑ Lack of sex drive
- ❑ Nocturia
- ❑ Painful urination
- ❑ Small stream
- ❑ Stones
- ❑ Straining
- ❑ Unusual color
- ❑ Urethral discharge
- ❑ Urgency

MUSCULOSKELETAL

- ❑ Arthritis
- ❑ Back pain
- ❑ Joint pain
- ❑ Joint stiffness
- ❑ Leg cramps
- ❑ Myalgias
- ❑ Spinal stenosis
- ❑ Swelling
- ❑ Trauma

HEMATOLOGIC LYMPHACYTIC/BLOOD DISORDERS

- ❑ Anemia
- ❑ Bleeding
- ❑ Easily bruised
- ❑ Lymph node enlargement
- ❑ Multiple Myeloma
- ❑ Other- _____

NEUROLOGICAL

- ❑ Depression
- ❑ Dizziness
- ❑ Gait disorder
- ❑ Headaches
- ❑ In coordination
- ❑ Lack of concentration
- ❑ Loss of memory
- ❑ Loss of sensation
- ❑ Paralysis
- ❑ Seizures
- ❑ Slurred speech
- ❑ Tingling/Burning/Numbing
- ❑ Tremors
- ❑ Vertigo
- ❑ Weak grip

ENDOCRINE

- ❑ Cold intolerance
- ❑ Diabetes
- ❑ Goiter
- ❑ Heat intolerance
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Hypoglycemia
- ❑ Other- _____

INFECTION

- ❑ Environmental allergies
- ❑ History of hives
- ❑ Multiple allergies
- ❑ Seasonal allergies
- ❑ None

CHILDHOOD ILLNESSES

- ❑ Chickenpox
- ❑ Measles
- ❑ Mumps
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Scarlett fever
- ❑ Whooping cough