DESERT SUN GASTROENTEROLOGY

7140 E Rosewood St.
Tucson, AZ 85710
Phone: 520.547.4900
Fax: 520.547.2435
www.dsgastro.com

DESERT SUN GASTROENTEROLOGY
DSG Policies Consent Form

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

Policies for Desert Sun Gastroenterology

Failure to cancel an appointment within 24 hours or no-shows for appointments will be charged a $25.00 fee.

- Please note that if you are a patient of Dr. Craig Gross, MD, at the time of your appointment only the patient will be allowed in the examination room. After the physician has examined the patient, he will briefly answer questions from a family member.
- Please turn your cell phone **off** while in the building.
- Please no food or drink in the building.
- If you need a refill on your medication, please contact the pharmacy and allow 72 hours for the doctor to approve the refills. Please do not call after hours or on the weekends for refills.
- Referrals can take up to 7 business days. It is always advisable for you to call your insurance company to check on your benefits.
- We will call you with your results after your doctor reviews them. This may take up to one week. Some special tests may take longer.
- Records sent to outside physicians / Clinics are faxed as a courtesy. For Insurance, personal and legal purposes, there will be a $25.00 fee for the first 10 pages, and .25 cents for each additional page plus current postage rate. These fees are due prior to forms being filled out.
- If there are Disability, FMLA or any other forms that require one of our physicians to fill out, due to the time to review and examine the patient chart, there is a $35.00 charge for the first side of a form, then $5.00 per side after. These fees are due prior to forms being filled out.
- There will be a $50.00 charge for any letter written by one of our physicians. These fees are due prior to forms being filled out.
- If you are a scheduled for a procedure at **Desert Sun Surgery Center**, they have a cancellation policy that states “if you fail to cancel your appointment within 48 hours or no-show for your appointment there will be a $100 charge”.
- If we refer you to an outside facility for X-rays, Scans, MRI, or any other procedure, not performed by one of our physicians, please notify this office if you have not received a call from them within one week.
- Desert Sun Gastroenterology can use or disclose (release) your health information that identifies you for potential research studies. The health information may be used by and/or disclosed (released) to Desert Sun Clinical Research.
- Desert Sun is required by law to protect your health information. By signing this document, you authorize Desert Sun to use and/or disclose (release) your health information for research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.
- I understand that at times, a CMA (certified medical assistant) working under the doctor’s order may administer an injection.

Signature: _____ Date: _____

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Explanation of Your Bill

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For Desert Sun Surgery Center, the total cost for your medical services may be comprised of four fees: The Physician's fees, the Surgery Center's fee, Pathologist's fee and Anesthesiology fee. Each fee will be billed separately by the provider of the service.

- The physician's professional fee is for providing the procedure and interpreting results.
- Desert Sun Surgery Center's bill is separate from the physician's bill. The surgery center's fee covers facility costs, which include the cost of nurses, technicians, equipment and supplies involved in the performance of your procedure.
- If biopsies are performed during your procedure, you will be billed separately by the Pathologist and/or Pathology Company reviewing the biopsy.
- Desert Sun Surgery Center subcontracts with Board Certified Anesthesiologists. You will be billed separately for their services.

We receive a quote of benefits and/or pre-certification/predetermination prior to your procedure(s). We encourage all patients to call their insurance company to request a quote of benefits/notification prior to their procedure(s), so that they can be made aware of their financial responsibility. Also, each plan has specific time periods as to how often a patient can receive a screening or diagnostic colonoscopy. We recommend you discuss with your carrier these frequency limits.

In most cases, we call patients prior to their appointment as a courtesy to inform them of their financial responsibility up front. If there is no call received, the patient is more than welcome to call the office themselves to discuss the insurance benefits quoted.

It is fully understood that the verbal financial responsibility is only an **ESTIMATE** based on a baseline procedure, which may change after insurance benefits have been settled and/or if additional procedures are performed, such as a biopsy of an abnormal finding and/or polyps removed. After insurance has been settled, if there is a credit balance on your Desert Sun Gastroenterology account the credit balance will be refunded back to you. This may take 30 to 90 days.

Desert Sun Surgery Center is a Medicare Certified facility and we are required to follow Medicare and State guidelines. Arizona Department of State article, 17, Outpatient Surgical Centers, specifically, R9-10-1707, Admission. Centers for Medicare and Medicaid Service standards G, 416.52(a) Standard: Admissions and Pre-Surgical Assessment. These articles read; A patient must have a comprehensive medical history and physical no more than 30 days before the date of the scheduled surgery. If you do not have a procedure within the 30 days, you will be required to re-consult. We recommend you check with your insurance for specific plan benefits if this were to occur.

How procedure is coded:
Our office has been asked to schedule you for a procedure that your doctor has recommended. **You need to be informed that if the physician performing your procedure finds a polyp or abnormality, your benefits may change and your insurance company may pay differently (as a diagnostic procedure instead of a screening procedure.)** If you have any further questions or concerns, feel free to call our billing department at 520-547-4900 option 1.

_____ _____

Signature Date

CC: Patient

Cmt 3/2013

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DESERT SUN GASTROENTEROLOGY
HIPAA Notice

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or your protected health information may be provided to a physician to whom you have been referred or seek counsel from, to ensure that physician has the necessary information to diagnose or treat you.

Treatment and office visits in our facility will require that you be called by name in the reception area. You will be asked personal and medical history questions by medical personnel to ensure safe and appropriate care in our surgery center. You may share a pre- or post-op area with other patients in our surgery center.

Obtaining approval or scheduling procedures or a hospital stay may require that your relevant protected health information be disclosed to the health plan or medical facility.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, medical studies, and conducting or arranging for other business activities. You may be greeted by name at our reception desk and ask to complete registration forms or sign consent for procedures. We may also call you by name in the reception area when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or inform you of test results. We may contact you by telephone, E-mail, Postal Service or other forms of delivery services, as your doctor deems necessary.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

DESERT SUN GASTROENTEROLOGY
HIPAA Notice

DESERT SUN GASTROENTEROLOGY **Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD**

Telephone calls to Desert Sun Gastroenterology may be monitored or recorded randomly, by management, for quality assurance or training purposes only.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

Your Rights Regarding Your Health Information

You have the right to inspect and copy your protected health information. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must submit your request for medical records in writing to your Doctor.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request, in writing, must state the specific restriction requested and to whom you want the restriction to apply. *(Please ask the receptionist for a form.)*

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You also have the right to request, in writing, to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to ask your physician to amend your protected health information. If you believe your medical record is incorrect or incomplete, you may amend your record through the use of an authorized amendment form. The original form must be placed into your medical file at this practice. You may request an amendment form from this office. Your request must be made in writing and submitted to your doctor at Desert Sun Gastroenterology, 7140 E. Rosewood Street, Tucson, AZ 85710. The original information will also be retained in your file.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided in this notice.

Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with us by notifying our HIPAA Compliance Officer. We will not retaliate against you for filing a complaint.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. You may ask our office for a copy of this Notice at any time. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (520) 547-4900.

DESERT SUN GASTROENTEROLOGY
Medication List

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

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Name _____

Date _____

Please complete this form and bring to your appointment.

Please list all medications you are taking, including over-the-counter products (e.g., aspirin, antacids, vitamins and herbals).

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

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DESERT SUN GASTROENTEROLOGY
Patient Payment Policy

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

Patient Responsibility:
You are responsible for all charges resulting from treatment provided by Gastroenterology Clinics. We bill most insurance carriers. However, primary responsibility for the account is yours. Your copayment is always due at the time of service; any remaining balance owed by you is due when you receive your invoice, unless other financial arrangements are made. For your convenience we accept cash, check, Visa, MasterCard and Discover.

Insurance Billing:
It is your responsibility to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care.

Desert Sun will call to verify insurance eligibility and request "general description" of insurance benefits. It is **ultimately the responsibility of the patient** to know his or her particular plan, weather our physicians are contracted, insurance benefits, deductibles, co-pays, policy provisions etc; as the insurance company will not guarantee payment of the benefits they quote.

For those enrolled in insurance products that require a referral, the primary care physician's office coordinates and "initiates" the referrals for our services. It is the patient's responsibility to have the referral "in hand" on the date of service.

Payment is due at the time of service. This includes; co-pays, deductibles, percentages, and self-pay patients. If balance is written off internally to bad debt, there will be a 10% fee added. If charges are sent to an outside collection agency, there will be a minimum fee of 30% but can increase based on age of the balance along with any legal fees or any fees added to the delinquent balance.

We will file your insurance for you if we are a participating provider on your plan. You will be responsible for any and all balances in excess of your insurance limits as well as any non-covered services.

If we are not a participating provider for your plan, full payment is due at the time of service.

We will mail you a monthly billing statement for any outstanding balances.

Charges are based on medical documentation. Codes will not be changed to suit the coverage of the individual policies with insurance companies.

Missed Appointments:
Desert Sun charges a $25.00 cancellation fee for less than 24 hours for an office visit and $100.00 cancelation fee for procedures canceled less than 48 hours.

Returned Check:
It is our office policy to charge a $35.00 fee for checks that are returned due to non-sufficient funds.

Authorization to Release Information:
In obtaining payment for services, I authorize my healthcare provider, Desert Sun Gastroenterology, to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including but not limited to: my insurance companies and their representatives. I understand that this consent is voluntary, if I refuse to sign this consent, Desert Sun Gastroenterology can refuse to treat me.

If I have been referred by, or am referred to another healthcare provider, I authorize Desert Sun Gastroenterology to release my medical information to this provider for continuing care.

I also assign Desert Sun Gastroenterology all payments to which I am entitled for medical expenses related to the services reported herewith. I understand that I am financially responsible for all charges whether covered by my insurance provider or not.

I have received a copy of the **Notice of Privacy Standards** which more fully describes the uses and disclosers that can be made with my individually identifiable health information for the treatment, payment and health care options.

I, or my appointed agent, have read, fully understand, and agree to the above statements.

Patient's Name (please PRINT)	Patient's Signature	Date

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DESERT SUN GASTROENTEROLOGY

Patient Record of Disclosures

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave Message with call-back number only

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other (Spouse, Children, Etc)

_____

_____

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of , and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entitles must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

For Office Use Only

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Discription of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T= Treatment Records; P= Payment Information; O= Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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DESERT SUN GASTROENTEROLOGY

DSG Patient Registration

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

Patient Information:

Legal Name: _____
Last First Middle Preferred Name (Nick Name)

Sex ☐Male ☐ Female ☐Trans Gender Date of Birth: ____/____/____ SS#: _____-____-_____

Home Address: _____
Street City/Town State Zip Code

Home Phone: (__) _____ Cell Phone: (__)_____ Business Phone: (__)_____

Email Address: _____

Emergency Contact: _____ Emergency Phone: _____ Relationship: _____

Please Circle:

Marital Status: Married / Single / Divorced / Widow

Ethnicity: Hispanic / Non Hispanic / Refused To Report

Race: White / Black or African American / American Indian/ Alaska Native / Asian / Native Hawaiian or Other Pacific Islander / Other Race / Refused To Report

Language: English / Indian (includes Hindi & Tamil) / Spanish / Russian

Appointment Notification Preference: Home Phone ☐ Cell Phone ☐ Text Message ☐ Work ☐
Select one:

How did you hear about us? _____

Employment Status:

Are You (please circle): Full-time / Part-time / Self Employed / Disabled / Currently Unemployed / Student / Retired

Employer: _____ Phone:_____ Occupation: _____

Address: _____
Street City/Town State Zip Code

Continued on next page:

DESERT SUN GASTROENTEROLOGY

DSG Patient Registration

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Pharmacy Information:

Primary Care Physician: _____ Referring Physician: _____ Phone: _____

Pharmacy Name : _____ Location: _____ Pharmacy Phone: _____

Insurance Information:

1.) Primary Insurance Name: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship: Self Spouse Dependant Employers Name: _____

2.) Secondary Insurance Name: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship: Self Spouse Dependant Employers Name: _____

Are you currently on AHCCCS? Yes / No

Have you recently applied for AHCCCS? Yes / No

If **YES** When & Where (Date: ___ / ___ / ___) (Where: _____)

1. I understand, by signing, the information above is complete and accurate and I DO NOT have any other insurance coverage and I am required by law to notify this office of any other Primary Insurance coverage.
2. I understand I am responsible for charges not covered by the above agents. I agree, in the event of non-payment, to assume the cost of interest collection and legal action (if required).
3. I authorize my insurance carrier to release information regarding my coverage to Desert Sun Gastroenterology.
4. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Desert Sun Gastroenterology.

Signature: _____ **Date:** _____

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DESERT SUN GASTROENTEROLOGY
Patients Rights & Responsibilities

DESERT SUN GASTROENTEROLOGY **Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD**

Patients Rights and Responsibilities

Patient Rights:

- Desert Sun Gastroenterology, Desert Sun Surgery Center, Desert Sun Research and medical staff have adopted the following statement of patient rights. This list shall include, but not be limited to, the patient's right to:
- Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.
- Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
- Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.
- Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Formulate advance directives regarding his or her healthcare, and to have ASC staff and practitioners who provide care in the hospital comply with these directives (to the extent provided by state laws and regulations).
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the practice &/or ASC. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of the request).
- Reasonable responses to any reasonable request he/she may make for service.
- Leave the practice &/or ASC even against the advice of his/her physician.

- Reasonable continuity of care.
- Be advised of the practice &/or ASC grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge time is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the practice &/or ASC contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the ASC.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- Know which the practice &/or ASC rules and policies apply to his/her conduct while a patient.
- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- **All hospital personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.**

Patient Responsibilities:

- The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:
- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the practice &/or ASC or physician when he/she is unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her hospital care are fulfilled as promptly as possible.
- The patient is responsible for following the practice &/or ASC policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and the practice &/or ASC personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the hospital.

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DESERT SUN GASTROENTEROLOGY

DSG Screening Vs. Diagnostic

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

IF YOUR COLONOSCOPY HAS BEEN SCHEDULED FOR A SCREENING (MEANING YOU HAVE NO SYMPTOMS WITH YOUR BOWELS)*, AND IF YOUR DOCTOR FINDS A POLYP OR TISSUE THAT HAS TO BE REMOVED DURING THE PROCEDURE, THIS COLONOSCOPY IS NO LONGER CONSIDERED A SCREENING, IT IS NOW CONSIDERED A SURGICAL/DIAGNOSTIC COLONOSCOPY AND YOUR INSURANCE BENEFITS MAY CHANGE. PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO STARTING THE BOWEL PREPARATION.

***SYMPTOMS SUCH AS; CHANGE IN BOWEL HABITS, DIARRHEA, CONSTIPATION, BLEEDING, ANEMIA, PAIN, ETC.**

Signature: _____ **Date:** _____

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DESERT SUN GASTROENTEROLOGY

Review of Systems

Craig G. Gross, MD / Gary P. Gottlieb, MD / John K. Tsai, MD / Cristiana Bortuzzo, MD

Review of Systems

Patient Name: _____

Have you experienced the following since your last visit here, or if this is your first visit, in the last 3 months?

Constitutional

☐ Y ☐ N Weight Loss
☐ Y ☐ N Decreased appetite
☐ Y ☐ N Insomnia
☐ Y ☐ N Fatigue
☐ Y ☐ N Fever or chills

Eyes

☐ Y ☐ N Blurred or double vision
☐ Y ☐ N Change in color vision

Cardiac

☐ Y ☐ N Chest pain
☐ Y ☐ N Abnormal heart rhythm

Respiratory

☐ Y ☐ N Difficulty breathing
☐ Y ☐ N Cough

Gastrointestinal

☐ Y ☐ N Abdominal pain
☐ Y ☐ N Heartburn
☐ Y ☐ N Nausea or vomiting
☐ Y ☐ N Diarrhea
☐ Y ☐ N Constipation
☐ Y ☐ N Blood in stool or on toilet paper
☐ Y ☐ N Black stool
☐ Y ☐ N Gas or bloating
☐ Y ☐ N Difficulty swallowing

Musculoskeletal

☐ Y ☐ N Joint pain, back or neck pain, or arthritis
☐ Y ☐ N Muscle aches or weakness

Endocrine

☐ Y ☐ N Thyroid disorder

Skin

☐ Y ☐ N Rash
☐ Y ☐ N Itching
☐ Y ☐ N Sweating or night sweats

Neurological

☐ Y ☐ N Headache
☐ Y ☐ N Dizziness

Psychiatric

☐ Y ☐ N Suicidal thoughts
☐ Y ☐ N Irritability / anxiety / nervousness
☐ Y ☐ N Depression
☐ Y ☐ N Difficulty concentrating

Hematologic / Lymphatic

☐ Y ☐ N Bleeding
☐ Y ☐ N Bruising

Past medical history

☐ Y ☐ N Heart disease
☐ Y ☐ N Lung disease
☐ Y ☐ N Blood thinners
☐ Y ☐ N Hepatitis or other liver disease
☐ Y ☐ N Pancreatitis
☐ Y ☐ N Cancer

Any other symptoms you are experiencing?

_____

_____

Doctor's Initials _____

DESERT SUN GASTROENTEROLOGY

DSG SmartPhone & Mobile Communications

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Smartphone/Mobile Communication device use in the office:

Use of a smartphones, mobile communication devices, and any type of imaging/recording equipment (electronic or conventional, audio or visual) in any part of the office is strictly prohibited for all persons, including patients. The only exception is for physician staff who may use photographic equipment for documentation. Particularly, employees and patients are prohibited from using smartphones/mobile communication devices or other audio recording/photographic equipment around patients, medical records, proprietary materials and processes, and in areas of the workplace devoted to patient care, research, and development. All images or recordings taken with smartphones or other photographic equipment in the office are subject to review at any time.

The reason for this policy is to protect:

- All persons who enter or work in the office
- Patient and medical record privacy
- Confidential business information

During office visits, patients are prohibited from using smartphones/mobile communication devices to make any audio or video recordings such as to record consent discussions, medication orders, or follow-up instructions. Such recordings breach the confidentiality rights of other patients and infringe on the privacy rights of physicians and their employees.

If a patient is discovered to be recording conversations, it is our policy to politely ask them to discontinue the activity immediately. Patients and/or their caregivers may takes notes during office visits to help them remember important information and emphasize that all office conversations will be documented in the medical record.

Signature: _____ Date: _____