Denver Esophageal & Stomach Center

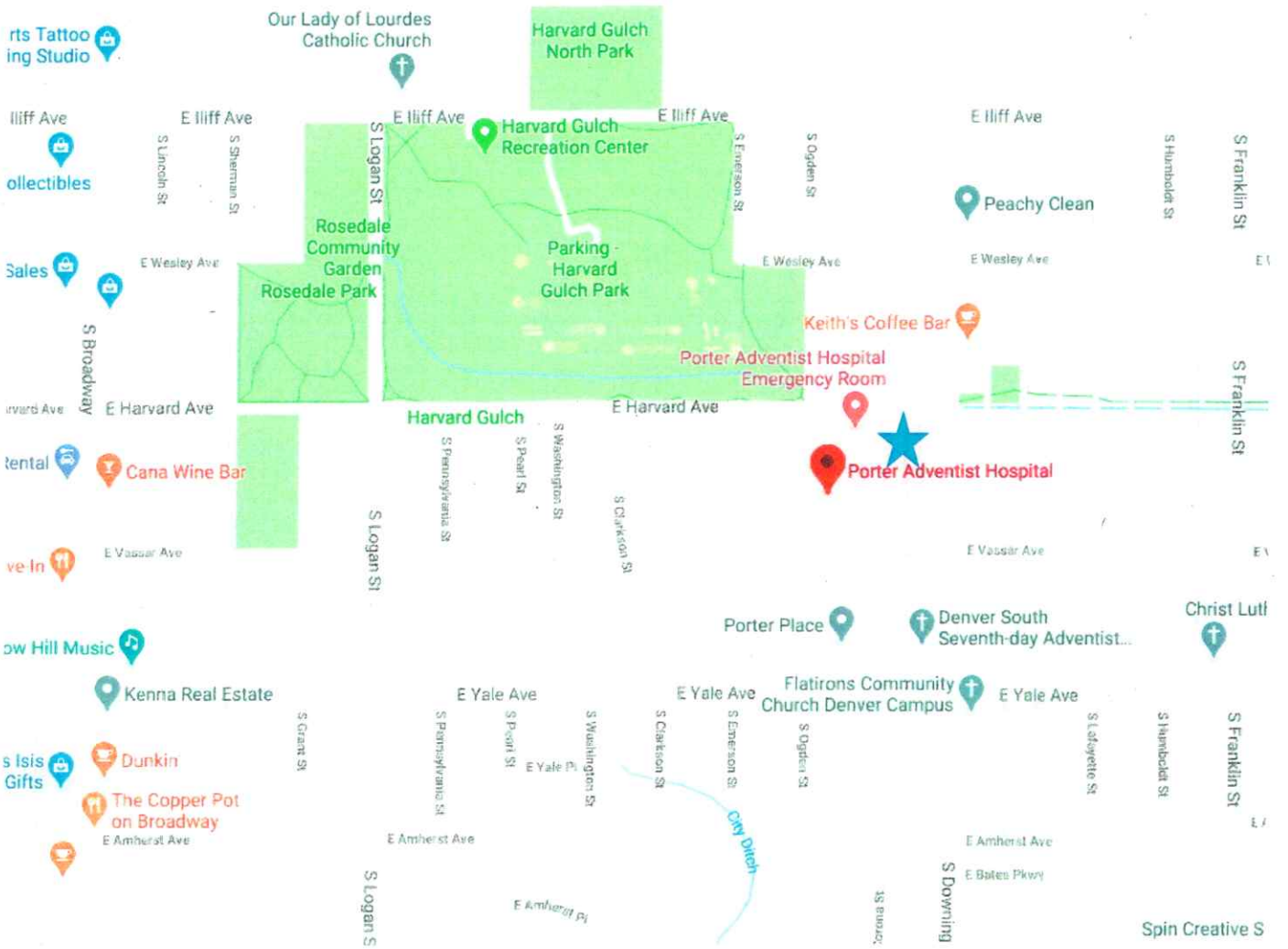
An Affiliate of SurgOne, P.C.

Ashwin Kurian, MD
Ahmed Zihni, MD

2535 S. Downing St.
Suite 400
Denver, CO 80210

The clinic is located in the Porter Medical Plaza building.

Phone: 720-508-8855 **Fax: 303-645-4992**



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Patient Information:

First Name: _____ Last Name: _____

Male:___ Female:__

Date of Birth: Month:_____ Day: _____ Year:_____

Height:____ Weight:_____

Medical History/ Review of Systems:

Medical Providers to Receive Correspondence: (PCP, Referring Doctor):

_____

_____

Reason for Visit: _____

_____

Medications: Please List All Medications Including Dosage:

None ( )

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____

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Medication Allergies

No Known Allergies ( )

1. _____
2. _____
3. _____
4. _____
5. _____

Past Medical History: Mark all that apply

None ( )

Acute MI	( )	High Blood Pressure	( )
Anxiety Disorders	( )	Hypothyroidism	( )
Aspiration Pneumonia	( )	Irritable Bowel	( )
Asthma	( )	LPR	( )
Arthritis	( )	Renal Disease	( )
Barrett's Esophagus	( )	Obesity	( )
Bloating	( )	Osteoporosis	( )
COPD	( )	Pulmonary Embolism	( )
Congestive Heart Failure	( )	Reaction to Anesthesia	( )
Crohn's Disease	( )	Sleep Apnea	( )
Depression	( )	Sinusitis/Sinus Infections	( )
Diabetes	( )	Stroke Syndrome	( )
Esophagitis	( )	Thyroid Disorders	( )
Flatulence	( )	Esophageal Perforation	( )
Gastroparesis	( )	Achalasia	( )
Gastric Ulcer	( )	DVT	( )
Esophageal Stricture	( )	Cardiac Arrhythmia	( )
Esophageal Reflux/GERD	( )		
Hiatal Hernia	( )		
High Cholesterol	( )		

Other: _____

_____

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Previous Surgical History: Mark all that apply

None ( )

Enterra ( )
Esophageal Ablation ( )
Esophageal Dilation ( )
Gastric Bypass ( )
Heller Myotomy ( )
Kidney Surgery ( )
LINX ( )
POEM ( )
Pyloroplasty ( )
Gastrectomy ( )

Other:_____
_____

Appendectomy ( )
Cholecystectomy (Gallbladder) ( )
Colon Surgery ( )
Gastric Surgery ( )
Surgery of Esophagus ( )
Sinus Surgery ( )
Facial Surgery ( )
Cardiovascular Surgery ( )
Neck Surgery ( )
Throat Surgery ( )
Orthopedic Surgery ( )
Inguinal Hernia Repair ( )
Incisional Hernia Repair ( )
Thyroid Surgery ( )

Family History: Mark all that apply

None ( )

Gallbladder Disease ( )
__ Father __ Mother
__ Brother __ Sister

Diabetes Mellitus ( )
__ Father __ Mother
__ Brother __ Sister

Adverse Reaction to Anesthesia ( )
__ Father __ Mother
__ Brother __ Sister

Bleeding Problems ( )
__ Father __ Mother
__ Brother __ Sister

Breast Cancer ( )
__ Father __ Mother
__ Brother __ Sister

Other Cancer: _____

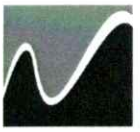
Ovarian Cancer ( )
__ Mother __ Sister

Heart Attack ( )
__ Father __ Mother
__ Brother __ Sister

Colon Cancer ( )
__ Father __ Mother
__ Brother __ Sister

Esophageal Cancer ( )
__ Father __ Mother
__ Brother __ Sister

Gastric Cancer ( )
__ Father __ Mother
__ Brother __ Sister



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Social History

Do you drink alcohol? Yes: ( ) No: ( )

If yes, how much: _____/day/week/month

Do you smoke cigarettes? Yes: ( ) No: ( )

If yes, number of cigarettes per day:_____

If current smoker, how many years: _____

If former smoker, when did you quit:_____

Are you on a special diet? Yes: ( ) No: ( )

If yes, describe:_____

_____

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Review of Systems: Mark all that apply for the last 6 months

Cardiac:
None:_____( )
Chest Pain:_____( )
Pacemaker:_____( )
Heart Valve:_____( )

Respiratory:
None:_____( )
Shortness of breath:_____( )
Chronic Cough_____( )
Bronchitis:_____( )
Pneumonia:_____( )
Sleep Apnea:_____( )
Wheezing:_____( )

Gastrointestinal:
None:_____( )
Abdominal Pain:_____( )
Nausea:_____( )
Vomiting:_____( )
Constipation:_____( )
Diarrhea:_____( )
Heartburn:_____( )
Regurgitation:_____( )
Difficulty Swallowing:_____( )
Rectal Bleeding:_____( )

Musculoskeletal/Skin:
None:_____( )
Back/Neck/Joint Pain:_____( )
Loss of Sensation:_____( )
Arthritis:_____( )
Osteoporosis:_____( )

Neurological:
None:_____( )
Numbness/Tingling:_____( )
Loss of Strength:_____( )
Headaches:_____( )

Cancer:
None:_____( )
Type:_____
Date:_____
Treatment:_____

Endocrine:
None:_____( )
Fatigue:_____( )
Excess Thirst:_____( )
Diabetes:_____( )
Thyroid Problems:_____( )
Weight Loss:_____( )

Constitutional:
None:_____( )
Fever:_____( )
Chills:_____( )
Night Sweats:_____( )

Blood/Immune:
None:_____( )
Anemia:_____( )
Blood Clots:_____( )
Lupus:_____( )

Psychological/Emotional:
None:_____( )
Anxiety:_____( )
Depression: _____( )

Head/Neck/Eyes/Ears:
None:_____( )
Ear Symptoms:_____( )
Eye Symptoms:_____( )
Nose/Sinus Symptoms:_____( )
Throat Symptoms:_____( )

SurgOne, P.C.

PATIENT INFORMATION

Requesting/Referring Provider: _____ ***Primary Care Provider:*** _____

Name (Legal): ***Last:*** _____ ***First:*** _____ ***M.I.*** ____ Preferred Name: _____

Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

Sex: M / F ***Marital Status:*** S / M / D / W ***Date of Birth:*** ____ ____ ____ ***Age:*** _____
MM DD YYYY

SS#: ____-____-____ ***Email:*** _____

Phone: ***Home*** ( ) _____ ***Work*** ( ) _____ ***Cell*** ( ) _____

Patient's Employer: _____ *Patient's Occupation:* _____

Employer's Address: _____ Employer's Phone #: _____

Emergency Contact: _____ Phone#: _____ Relation: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ ***Phone #:*** _____

Address/ Location: _____

INSURANCE INFORMATION

☐ **Legible Copy of Ins. Card** ☐ **Copy of Driver's License**

PRIMARY Insurance: _____ ***Subscriber ID#:*** _____

Group# _____ ***Mailing Address (for claims):*** _____

Policy Holder Name _____ ***Relationship:*** Self / Spouse / Child / Other _____

Policy Holder DOB: _____ ***Ins. Phone #:*** ( ) _____ ***Policy Holder Employer:*** _____

If Accident: ☐ WorkComp or ☐ Auto: Date of Injury _____ Claim No. _____

SECONDARY Insurance: _____ ***Subscriber ID#:*** _____

Group# _____ ***Mailing Address (for claims):*** _____

Policy Holder Name _____ ***Relationship:*** Self / Spouse / Child / Other _____

Person Responsible for Payment of Services (If different from Patient): _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I WILL FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION, TO INCLUDE ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

I HEREBY ASSIGN MY RIGHT AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO SURGONE FOR THESE SERVICES AND ALL FUTURE CLAIMS AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

X _____ (Signed) Date: _____

(Revised 03 20 17)

SurgOne, P.C.

Protected Health Information and Communication Consent

Your physician and/or the staff may at times need to contact you and/or discuss your care with those persons whom you give us consent to do so. By completing the information below, we will be better able to serve you.

In an effort to protect your privacy and follow new federal guidelines, we have developed a policy regarding leaving medical care messages and/or discussing your care with others:

- We will ***NOT*** leave messages on voice mail or answering machines ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO***.
- We will ***NOT*** discuss your care with others ***UNLESS WE HAVE WRITTEN PERMISSION TO DO SO***.

PATIENT NAME: _____ Birth Date:_____

		May we leave a message?		**May we discuss your care?**	
HOME PHONE:	_____	Yes	No	Yes	No
WORK PHONE:	_____	Yes	No	Yes	No
CELL PHONE:	_____	Yes	No	Yes	No
EMAIL*:	_____			Yes	No

(*Please note that most standard email addresses (yahoo, comcast, hotmail, aol, etc)are not secure/HIPAA compliant. By writing in your email above and circling YES, you are giving us permission to contact you via unsecure email).

Please carefully consider with whom we may leave messages and/or whom you wish to have us communicate with in regards to your medical and/or billing information:

Spouse or Partner	Yes	No	If yes, name:_____
Son or Daughter	Yes	No	If yes, name:_____
Mother or Father	Yes	No	If yes, name:_____
Friend/Neighbor	Yes	No	If yes, name:_____
Other	Yes	No	If yes, name:_____

Notes:_____

Voice mail or answering machine messages may include the following information:

Specific information regarding my surgery/treatment	Yes	No
Scheduling for Lab/Test/Surgery	Yes	No
Results for Lab/Test/Surgery	Yes	No

I fully understand that this consent will remain valid until revoked in writing by me.

SIGNATURE:_____ **DATE:**_____

Revised 03/01/2017

SurgOne, P.C. Cancellation Policy

At SurgOne, P.C. ("SurgOne"), we strive to render care in a timely and prompt manner. When a patient misses a scheduled appointment, or cancels an appointment with minimal notice, not only is that time lost, but it negatively impacts our ability to schedule other patients that require medical care. SurgOne has thus adopted the following Cancellation Policy. By signing below, you hereby acknowledge and agree to the following:

- Any patient that fails to show up for a scheduled appointment or cancels a scheduled appointment with less than 48 business hours' notice, will be charged a Cancellation Fee.
- Cancellation Fees can range from $25.00 up to $200.00 depending on the length of the appointment and the specialty of the provider with whom it was scheduled. SurgOne can provide the exact amount of a Cancellation Fee at the time an appointment is scheduled.
- All outstanding Cancellation Fees must be paid in full prior to the scheduling of a patient's next appointment with SurgOne.
- Patients are solely responsible for the payment of Cancellation Fees, not insurance companies, Medicare, or other third-party payers.
- If a patient is more than 15 minutes late for a scheduled appointment, SurgOne reserves the right to reschedule the appointment.
- Any patient who, in a given 12-month period, misses three or more scheduled appointments, or cancels three or more scheduled appointments with less than 48 business hours' notice, may be dismissed as a patient from SurgOne.

I have read and understand the above SurgOne Cancellation Policy and I agree to be bound by its terms.

_____
Patient Signature

_____
Patient Name

_____
Date

SURGONE, P.C. FINANCIAL POLICY

Thank you for choosing SurgOne, P.C. for your healthcare. In order to achieve our goal of providing and maintaining a good physician-patient relationship, we believe it is important to have solid financial policies in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following SurgOne, P.C. Financial Policy prior to your treatment.

- Upon arrival, please sign in at the front desk and present your current health insurance card as well as your driver's license or another acceptable form of ID. You may be asked to present both of these items at each visit for proper identification.
- If you do not have health insurance coverage, choose to bill your own insurance, or if our physicians do not participate in your health insurance plan, payment IN FULL is due at the time of service. Acceptable forms of payment are cash, check, VISA and MasterCard.
- You are responsible to make complete insurance information available to SurgOne, P.C. for accurate filing of claims. Complete insurance information includes current benefit cards (primary and secondary), proper identification, and referrals from other providers if applicable.
- You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that you may owe at the time of service.
- Co-payments are a contractual obligation with your insurance company. You are required to pay your co-payment, and we are required to collect your co-payment at the time of each visit. Co-payments are collected prior to service.
- If the insurance information that you provide at the time of your visit is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
- For indemnity-type health insurance plans, insurance payments received by SurgOne, P.C. will be applied to your account and you agree to pay the balance.
- If you have a HMO or PPO health insurance plan and our SurgOne, P.C. physicians participate in your plan, we will accept payment from the carrier for services covered by your benefit plan.
- Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility.
- SurgOne, P.C. is committed to providing the best treatment for our patients; however, you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.
- For scheduled appointments, prior balances must be paid prior to the visit.
- We require 48-hour notice for canceling any appointments. A cancelation fee may apply.
- A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- A $35 fee is required for the completion of patient forms regarding disability insurance, life insurance and FMLA.

- If you undergo a surgical procedure, in addition to a bill from your surgeon, you may also receive bills from the hospital or surgical center, the anesthesiologist, pathology/lab and/or radiology, depending on the procedure.

_____ Initial If you have a surgical procedure that requires the use of a surgical assistant, SurgOne, P.C. may not bill for those services. You will receive a separate bill from the surgical assistant. Most insurance companies do not have contracts with surgical assistants, therefore your assistant may be out of network. The surgical assistant may or may not be covered by your health insurance plan. If you have specific questions regarding surgical assistant services or whether an assistant will be required for a specific surgical procedure, please let your provider or the staff know.

- **It is your responsibility to know your healthcare benefits and coverage limitations.**

We will be happy to address any questions you may have after reading our Financial Policy. Please let our staff know if you would like a copy of this policy.

I have read and understand SurgOne, P.C.'s Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in the above policy. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my health insurance coverage.

_____
Patient's Printed Name

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Printed Name Relationship to Patient

_____ _____
Legal Guardian Signature Date

SurgOne, P.C.

Financial Responsibility Waiver

Patient Name: _____

I understand that I have received care or will receive care from SurgOne, P.C. and:

- ☐ I have **no Insurance coverage.** I am financially responsible for all services provided.

- ☐ I have **furnished my current insurance information** to SurgOne, P.C., for an insurance company currently contracted with SurgOne, P.C. I understand I will be responsible for any of my plan deductibles, co-pays, co-insurance, or for services that are not covered by my insurance plan plan. **(Remember, your insurance company may require a referral or precertification for your surgery, however, such a referral or precertification is not a guarantee of benefits.)**

- ☐ **I failed to furnish** insurance information **(a physical card for our office to copy.)** If I do not provide a copy of my current insurance card or the correct information within one week, SurgOne P.C. will bill me for my services. If my insurance information is provided after I have been billed, SurgOne, P.C. will then bill my insurance company. If I have paid for services and my insurance company also pays for those services, I understand SurgOne P.C. will reimburse me accordingly. **I understand it is my responsibility to obtain a current referral if required by my insurance company.**

- ☐ I have presented insurance information to SurgOne P.C., from an insurer with which SurgOne, P.C. is not contracted, therefore, I will be seen as an **out-of-network patient.** SurgOne, P.C. may bill my insurance company as a courtesy, but I understand that I am responsible for the balance of charges incurred. **(Please contact your insurance company for information regarding your out-of-network benefits, or if your claims have not been paid in a timely manner.) Thank you.**

- ☐ I have **failed to furnish a current referral** from my primary care physician. I understand that if my insurance company denies the charges for services provided to me, I will be financially responsible for those services. If my primary care physician does issue a referral and payment is made for my services after I have already paid for them, SurgOne, P.C. will reimburse me accordingly.

Referring Doctor: _____

Telephone Number: _____

Contact Name: _____

I have been advised that it is my responsibility to obtain the information needed so that SurgOne, P.C. may be reimbursed for services provided, and that if non-sufficient information is given, or if I do not have appropriate insurance coverage, payment arrangements must be made as soon as possible **(Billing department** _____). I understand that it is my responsibility to obtain a current referral if required by my insurance company. I assume full responsibility for the cost of services provided to me.

Thank you.

Date: _____ **Signature of Patient or Guardian:** _____

SurgOne, P.C.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I acknowledge that I am in receipt of the Notice of Privacy Practices for SurgOne, P.C.

_____
Print Name

_____ _____
Signature Date