



Northwest Gastroenterology, PLLC
2979 Squalicum Parkway, Suite #301
Bellingham, WA 98225

Northwest Endoscopy Center, LLC
2930 Squalicum Parkway, Suite #202
Bellingham, WA 98225

(360) 734-1420 * FAX (360) 734-8748

PATIENT INFORMATION

PATIENT'S NAME: *Mr. / Mrs. / Ms. / Dr.* _____

PATIENT'S SSN: _____ BIRTHDATE: ____/____/____ [] MALE [] FEMALE

MAILING ADDRESS: _____

CITY: _____ STATE: WA ZIP: _____ EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ POSITION: _____

PRIMARY CARE DOCTOR/PROVIDER: _____

MARITAL STATUS: [] Single [] Married [] Divorced [] Widowed [] Other: _____

SPOUSE/PARTNER: _____ HIS/HER BIRTHDATE ____/____/____ SSN ____-____-____

EMERGENCY CONTACT:

Name of relative/friend: _____ Phone: () _____

Relationship: _____ Cell Phone: () _____

I authorize NW Gastroenterology or NW Endoscopy Center to release information relevant to my medical history to the individual named below (example: Mother, Father, Brother, Sister or Friend). To verify their identity the individual may be requested to give the last 4 digits of their social security number or mother's maiden name, whichever is given as the identifier.

Name: _____ Identifier: _____

Patient

Signature: _____ Date: _____

I AUTHORIZE THE PHYSICIAN OR A MEMBER OF HIS CLINICAL SUPPORT STAFF TO CONTACT ME AND/OR LEAVE INFORMATION AS INDICATED BELOW.

(Unless given permission, this practice will not leave information on your home or cell message machine.)

Home Phone and answering machine: [] Yes [] No

Work Phone and voice mail: [] Yes [] No

Cell Phone and voice mail: [] Yes [] No

E-mail: [] Yes [] No

In addition, I hereby authorize you to contact me at any telephone number, including pager and cell phone numbers provided by me or otherwise obtained by you, using an automatic telephone dialing system.

PATIENT SIGNATURE: _____ **DATE:** _____

This authorization is valid until _____. As the patient, you have the right to contact the office and change your authorization for release of information at any time. This change **MUST** be in writing.

Staff: _____ DATE: _____

**NORTHWEST GASTROENTEROLOGY
NORTHWEST ENDOSCOPY CENTER
PATIENT CARE AGREEMENT**

We have established a Patient Care Agreement to avoid misunderstandings. Please read the policy carefully, if you have any questions a member of our staff will be happy to discuss the policy with you.

- We bill all major commercial insurance companies, Medicare, DSHS, L&I, and Tricare.
- We are unable to bill your insurance until we obtain a copy of your card. Without the card or a copy on file you may be responsible for the bill.
- If you do not have insurance, payment is expected at the time of service. We recognize that there may be times when full payment is not possible. Please contact our billing department at 360-543-5054 to set up a payment plan.
- **CO-PAYS ARE DUE AT THE TIME OF SERVICE.** The co-pay is an agreement made between the subscriber and the insurance company.
- We cannot accept responsibility for a disputed claim. If your insurance company denies the claim or withholds payment, you are ultimately responsible for the balance due.
- **PATIENT RESPONSIBILITIES**
 1. Patient agrees to provide our office with a current copy of insurance card/coupon. This includes information on secondary and tertiary plans.
 2. Patient agrees to pay co-pays on day of service.
 3. Patient agrees that if their insurance plan requires a referral from their primary care physician it will be their responsibility to obtain the referral.
 4. Patient agrees to provide NW Gastroenterology with updated information, home address and telephone numbers.
 5. Patient agrees to pay any balance due within 30 days of receipt
 6. Patients who cancel or no show without minimum notice (48 hours) risk being removed from our practice.
 7. Patient with unpaid accounts and/or accounts sent to collections may be removed from our practice.
 8. Patients who are not compliant and/or do not follow recommended treatment plan by our physicians may be removed from our practice.
- NW Gastroenterology will make every effort to work with you to arrange satisfactory payment of your bill. If however, payment is not received within 90 days of service and you have not contacted this office to arrange a payment plan collection activities will commence. NW Gastroenterology utilizes the services of an outside collection agency.

RELEASE OF BENEFITS AND INFORMATION: *I authorize the physician or insurance company to release any information for my claims. I authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I understand that NW Gastroenterology will not bill my insurance unless I provide them with a current copy of my insurance card and that unless I do so I am solely responsible for my entire bill.*

I have read and understand the Patient Care Agreement as noted above.

Signature of Patient

Date

DRUG ALLERGIES: It is very important for your physician to be made aware of ANY drug reactions you have experienced. List all medications including over-the-counter.

MEDICATION	REACTION
Do you have an allergy to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> I have no known drug allergies	

Do you use tobacco products? Yes No **If yes, please check** cigarettes cigars pipe chew
 How long have you been using tobacco products? Amount per day:
 If not using now, when did you quit? How much did you use before?

Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No (Using 2 oz of hard alcohol, 1 glass of wine or 1 beer as a serving indicate how much you drink)	per day	per week
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever used IV illicit drugs or snorted cocaine? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you have any tattoos?

Has anyone in your family (grandparent, parent, child, brother/sister, aunt/uncle, cousin) had any of the following conditions?

Liver problems	Colon cancer or "pre-cancerous polyps"	Ulcerative colitis or Crohn's Disease	Other cancer, please list
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Do you have any of the following?

Yes	No	(If "yes" also circle specific item)	<i>Please leave this area blank</i>
		Heartburn, regurgitation, swallowing problem, food getting stuck	
		Liver disease, hepatitis, jaundice	
		Blood in stool, change of bowel habits	
		Excessive fatigue, poor appetite	
		Unintended weight loss of greater than 5 pounds	
		Glaucoma, eye pain	
		Ringing in the ears	
		Oral ulcerations	
		Exertional chest pain, fainting	
		Sleeping propped up on pillows to prevent getting short of breath	
		Rheumatic fever, endocarditis, heart murmur, palpitations	
		Shortness of breath, wheezing, asthma, COPD	
		Sleep apnea, coughing up blood, recurrent pneumonias	
		Exposure to or at risk of TB (tuberculosis)	
		Blood, stool or air in the urine	
		Painful urination, urinary incontinence, kidney stones	
		Heavy periods, irregular periods, pregnant, breastfeeding	
		Joint pain or swelling: where?	
		Trouble walking	
		Rash, skin breakdown or skin ulcerations, drainage from the skin	
		Numbness	
		Seizures (including alcohol DTs), strokes, migraine headaches	
		Anxiety	
		Depression	
		Thyroid disease	
		Problem with sugar control (diabetes)	
		Bleeding disorder, excessive bleeding	
		Blood clots	
		Fevers	
		Unusual lumps on body	
		I HAVE NONE OF THE ABOVE	

Patient Signature: _____