COVID-19
ACTIVE SCREENING QUESTIONNAIRE

Your health and well-being are of the upmost importance and we are taking measures to keep the facility/office a safe environment for employees as well as the individuals under our charge and the public. Therefore, anyone coming into the facility/office will be screened and part of us
screening process will include taking their temperature and asking the following questions.

1. Within the last 14-days, have you experienced a new cough that you cannot attribute to another health condition? □ YES □ NO

2. Within the last 14-days, have you experienced new shortness of breath that you cannot attribute to another health condition? □ YES □ NO

3. Within the last 14-days, have you experienced a new sore throat that you cannot attribute to another health condition? □ YES□ NO

4. Within the last 14-days, have you experienced new muscle aches that you cannot attribute to another health condition or a specific activity such as physical exercise?

   □ YES □ NO

5. Within the last 14-days, have you had a temperature at or above 100.4˚ or the sense of having a fever? □ YES □ NO

6. Within the last 14 days, have you had close contact, without the use of appropriate PPE, with someone who is currently sick with suspected or confirmed COVID-19? * *(Note: Close contact is defined as within 6/feet for more than 10 consecutive minutes)*

   □ YES □ NO

If the individual answers YES to any of the questions they will not be allowed into the facility/office unless determined otherwise by a designated DOC medical professional.

PRODIGEST GASTROENTEROLOGY & ASSOCIATES
5750 Downey Ave., Suite 202
Lakewood, CA 90712
Phone : 562-634-4939 Fax : 562-634-4939

PATIENT INFORMATION (*please print*)

First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Work Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Date of Birth _____ Social Security #_____ Sex: __M __F

Marital Status: □ S □ M □ D □ W □ Other _____ How did you hear about us? _____

Primary Language _____ Interpreter Required: □ Yes □ No

Race _____ Ethnicity (*circle one*) Hispanic or Latino Not Hispanic or Latino

Employer _____ Employer Phone _____ Occupation _____

GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) _____ First _____ Initial _____

Date of Birth _____ Social Security # _____ Relationship _____

Employer _____ Address _____ Phone _____

INSURANCE INFORMATION (*please print*)

Primary Insurance _____

Policy Holder Name _____ DOB _____ Social Security #_____

Billing Address _____ City, State, Zip _____

Group or Policy #_____ Cert. or Member #_____ Local Union #_____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ Social Security #_____

Billing Address _____ City, State, Zip _____

Group or Policy #_____ Cert. or Member #_____ Local Union #_____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Pharmacy Information Patient INFORMATION (/ePrescribing (*please print*)

Pharmacy Name _____ Address _____ Phone _____

Mail Order Pharmacy Name _____ Phone _____ Fax _____

Emergency Contact Information

Please list two people who do not live with you that we may call in case we are unable to reach you and we have an urgent matter to discuss with you.

Note: NO CONFIDENTIAL INFORMATION SHALL BE DISCLOSED, SIMPLY TO REQUEST TO HAVE YOU CONTACT OUR OFFICE.

Emergency Contact Name	Relationship	Phone Number

Signature (Patient or Parent of Minor): _____ **Date:** _____

Authorization to Communicate Patient's Medical Information

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name of Person Authorized to received information	Relationship to patient	All	Medical	Appt. Only	Billing Only

Validation Code Word: _____ *(please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.*

Informative Required Information

Advance Directive given: Yes No Initials: ____ Adv. Directive Completed and on File Yes No

Signature (Patient or Parent of Minor): _____ Date: _____

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY I acknowledge that I received a copy of PROHEALTH PARTNERS, INC., and ProDigest Gastroenterology & Associates., M. Saliminejad M.D., F. Javadi M.D., J. Pantoja M.D. & B. Ueki M.D. financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION I authorize release of my medical record information, pursuant to applicable federal and state laws, rules, and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC., all my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC., for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC., are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

OTHER IMPORTANT INFORMATION: **OFFICE NO SHOW POLICY**

In order to assure the best appointment availability to our patients, we ask that you notify us at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule the appointment. Failure to give us 24 hour's notice will result with the following fees.

Cancelled appointment done less than 24 hours $35.00 /

Rescheduled appointments done less than 24 hours $35.00

No show $35.00

Rescheduled surgery done less than 48 hours $100.00

Cancelled surgery less than 24 hours $ 125.00

No show for surgery $150.00

Patient's Signature _____ Date: _____

Responsible Party Relationship to Patient _____

PRODIGEST GASTROENTEROLOGY & ASSOCIATES
5750 Downey Ave., #202 Lakewood, CA 90712
Telephone # 562-634-4939 Fax # 562-634-5809

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Do Not Use This Form If Records to Be Released Relate to HIV Test Results, Mental Health or Alcohol/Drug abuse)

EXPLANATION: This Authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected health information ("PHI") about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent us from acting on this Authorization.

Name of Patient: _____ Date of Birth: _____

Other Names: _____ Account #: _____

1. PERSONS AUTHORIZED TO DISCLOSE PHI. I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below*: (State name of physician or specific identification of person or class of persons)* _____

2. DESCRIPTION OF INFORMATION. This Authorization permits the use and/or disclosure of the following information about patient: *(Check all applicable boxes and initial selection as required).*

☐ _____ (Initial) All my health information marked below pertaining to any medical history, physical condition and treatment received. Except *(optional)*: _____

☐ Medical Office Records ☐ Hospital Records ☐ X-ray films & images ☐ Laboratory Results

☐ Other: _____

Or only the following records or types of health information and/or only on the specified date(s):
Date(s) of Treatment: _____ Type of Treatment: _____

☐ _____ (Initial) Other _____

3. AUTHORIZED USERS AND RECIPIENTS. I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above: *(State name and title if applicable.)*
Name: _____ **Title** (if applicable) _____
Address: _____ City, State, Zip _____

4. PURPOSE. I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purposes: (*Check all applicable boxes) (Researchers should note that this must be research study specific, not for future unspecified research release)*

☐ Requested by patient or personal representative. ☐ Other:

Physician or practice will be remunerated for this information. Yes ☐ No ☐

5. RIGHT OF REVOCATION. I understand that I have the right to revoke this authorization at any time, providing that my revocation is in writing and conforms to requirements described in the ProHealth Partners/Argus Notice of Privacy Practices.

6. LIMITS TO REVOCATION. I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested the Authorization, any revocation will be effective only when I communicate my revocation directly to them.

7. REDISCLOSURE. I understand that if the recipient of my information in Section 3 above is not a healthcare provider, a health plan, or a health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.

8. CALIFORNIA RESTRICTIONS. I understand that a recipient of medical information in California may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. RIGHT TO REFUSE TO SIGN. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment, or benefits.

10. AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified.
End date_____ Or Event _____

11. COPY RECEIVED. I acknowledge receipt of a signed copy of this authorization_____(Initials)

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Print name of Personal Representative (if applicable)	Relationship of Personal Rep. to Patient
_____	_____
Address	Phone number
_____	____ ____ _____
Type of pt./rep. ID presented. Attach copy (optional)	Verified Yes, No Initials who verified

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE

MEDICAL HISTORY & REVIEW OF SYSTEM FORM

FIRST NAME: _____ **LAST NAME:** _____

DATE: _____/_____/_____ **REFERRING PROVIDER:** _____

REASON FOR VISIT:
_____

CURRENT MEDICATIONS			ALLERGIES

PLEASE REVIEW AND CIRCLE EACH ITEM THAT RELATES TO YOUR HEALTH

GASTROINTESTINAL	LIVER / GALLBLADDER	SURGICAL HISTORY	SOCIAL HISTORY
☐ Stomach ulcer	☐ Hepatitis A	☐ Cesarean section	☐ Recreational drugs
☐ Heartburn	☐ Hepatitis B	☐ Hernia repair	**Smoking:**
☐ Acid reflux disease	☐ Hepatic C	☐ Appendix	☐ Never
☐ Problem swallowing	☐ Jaundice	☐ Gall bladder	☐ Former smoker
☐ Gastrointestinal bleeding	☐ Cirrhosis	☐ Cataract	☐ Current smoker
☐ Gastritis	☐ Gallstones	☐ Knee	**Drinking:**
☐ Nausea	☐ Fatty liver	☐ Shoulder	☐ Never
☐ Vomiting	☐ Alcoholic liver disease	☐ Back	☐ Occasional
☐ Abdominal pain	**PANCREAS**	☐ Heart surgery	☐ Former drinker
☐ Hiatal hernia	☐ Pancreatitis	☐ Stomach surgery	☐ Current drinker
☐ Bloating	☐ Cyst in pancreas	☐ Colon surgery	**MARITAL STATUS**
☐ Irritable bowel syndrome	**GENERAL DISEASES**	☐ Breast surgery	Single Married Widowed Divorce
☐ Diarrhea	☐ Diabetes	☐ Prostate surgery	Occupation:
☐ Constipation	☐ Kidney disease	☐ Weight loss surgery	**PRIOR STUDIES**
☐ Diverticulosis	☐ Dialysis	☐ Problem w/ anesthesia?	☐ Upper endoscopy

☐ Diverticulitis	☐ Lupus	☐ Other	☐ Colonoscopy
☐ Blood in stool	☐ Asthma	☐ No prior surgery	☐ ERCP
☐ Hemorrhoids	☐ COPD	**FAMILY HISTORY**	☐ Endoscopic ultrasound
☐ Anal fissure	☐ Depression	☐ No disease in my family	☐ CT scan
☐ Anemia	☐ Anxiety	☐ High blood pressure	☐ MRI
☐ Iron deficiency	☐ Back pain	☐ Diabetes	☐ Ultrasound
☐ H. Pylori infection	☐ Arthritis	☐ Heart disease	☐ Colon cancer screening
☐ Colitis or Crohn's disease	☐ Migraine / headaches	☐ Cancer (if yes, please explain)	☐ Other
☐ Lactose intolerance	☐ Problem urinating		
☐ Colon polyps	☐ Problem breathing	☐ Colonic polyp	
☐ loss of appetite	☐ HIV	☐ Clot or bleeding disorder	
☐ Other	☐ Gout	☐ Other	
CARDIOVASCULAR	☐ Thyroid disease		
☐ High blood pressure	☐ Cancer		
☐ High cholesterol	☐ Seizures		
☐ Stroke	☐ Weight loss		
☐ Heart attack	☐ Shortness of breath		
☐ Heart failure	☐ Chest pain		
☐ Pacemaker	☐ Palpitation		
☐ Artificial valve	☐ Problem sleeping		
☐ Blood clots	☐ Other		
☐ Blood thinners			
☐ Stents in heart			