Ronald J. Boisen, M.D.
Daryl M. McClendon, M.D.
Jeffrey W. Molloy, M.D.

Patient Information Form

Patient's Name: _____Age: _____ DOB: _____

Sex: _____Male _____Female Marital Status: _____S _____M _____W _____D _____Sep

Social Security Number (VA and Tri-Care patients only): _____

Race: __American Indian or Alaska Native __Asian __Black or African American __Hispanic

Native Hawaiian or Pacific Islander __White/Non-Hispanic __Other __Unknown

Ethnicity: _____Hispanic _____Non-Hispanic _____Unknown Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____

Spouse's Name: _____ Spouse's DOB: _____ Spouse's Phone: _____

Emergency Contact/Relation: _____ Emergency Contact Number: _____

Patient Referring Healthcare Provider or PCP: _____

Pharmacy & Preferred Location: _____

Primary Medical Insurance: _____ Policy Holder Name & DOB: _____

ID #: _____ Group #: _____

Secondary Medical Insurance: _____ Policy Holder Name & DOB: _____

ID #: _____ Group #: _____

Teriary Medical Insurance: _____ Policy Holder Name & DOB: _____

ID #: _____ Group #: _____

Person Responsible for the Bill if other than above: _____

Patient is responsible for all fees regardless of medical coverage. It is customary to pay at the time of service unless other arrangements have been made in advance.

I authorize Ronald J. Boisen, M.D., Daryl M. McClendon, M.D., and/or Jeffrey W. Molloy, M.D. to administer medical treatment.

Patient's Signature: _____Today's Date: _____

I authorize Ronald J. Boisen, M.D., Daryl M. McClendon, M.D., and/or Jeffrey W. Molloy, M.D., 3851 Piper Street, Suite U466, Anchorage, AK 99508 to release any medical information required by my insurance company or Worker's Compensation carrier for the processing of all medical claims on my behalf.

I authorize my insurance company(ies) _____ and _____ to pay benefits directly to Ronald J. Boisen, M.D., Daryl M. McClendon, M.D., and/or Jeffrey W. Molloy, M.D., 3851 Piper Street, Suite U466, Anchorage, AK 99508 for claims on my behalf. I agree to promptly sign over any checks that I receive within 7 days of receipt. I understand that those charges not covered by my insurance company are my own responsibility, and there is a monthly charge of 1% on the account over 90 days. In the event that my insurance company pays Ronald J. Boisen, M.D., Daryl M. McClendon, M.D., and/or Jeffrey W. Molloy, M.D., a fee which I have already paid, I understand that I will be promptly reimbursed.

I acknowledge and agree to the terms above:

Patient's Signature: _____ Today's Date:_____

Ronald J Boisen, M.D.
Daryl M. McClendon, M.D.
Jeffrey W. Molloy, M.D.

Patient Information Form

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____

Reason for Visit: _____
_____
_____
_____
_____

Medicines: List all medicines, birth control pills, or vitamins you take with or without a prescription including over the counter drugs. (e.g. Aleve, Tagamet 200. etc) Include herbs and aspirin. _____
_____
_____
_____
_____

Past Medical/History Problems

List of Past Medical/History Problems: (i.e. High Blood Pressure, Asthma, Heart Attack, TB, etc)

_____
_____
_____

Have you ever had:

Colon Polyps: Yes/No

Gastric Polyps: Yes/No

Ulcers: Yes/No

Liver Disease: Yes/No

Pancreatitis: Yes/No

Cancer: Yes/No Type:_____

Medicine Allergies:_____
_____
_____

Previous Procedures

Colonoscopy: Yes/No Year: _____

Upper Endoscopy: Yes/No Year: _____

Hospitalizations & Surgery

List IIIness/Operation & Approximate Year: _____
_____
_____

Family History

Gastrointestinal (Digestive Disease)

Relative/s with:

Gallstones: _____

Ulcer: _____

Polyps: _____

Pancreatitis: _____

Liver Disease: _____

Cancer: _____

Personal Social History

Alcohol: Yes/No Drinks per week: _____ Beers per week: _____

Smoking: Yes/No Cigarettes per day: _____ #of years: _____ #of years quit: _____

History of Injectable Drug Use: Yes/No

Marijuana Use, Frequency, & Form: _____
_____
_____
_____
_____

Ronald J. Boisen, M.D.
Daryl M. McClendon, M.D.
Jeffrey W. Molloy, M.D.

Review of Systems for the Last 12 Months

Name: _____Date of Birth:_____

Constitutional		
Recent Weight Change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Eyes		
Blurred Vision	Yes	No
Glaucoma	Yes	No
Ears/Nose/Mouth		
Hearing Loss	Yes	No
Ringing in Ears	Yes	No
Mouth Sores	Yes	No
Cardiovascular		
Chest Pain	Yes	No
Pacemaker	Yes	No
Cardiac Valve Disease	Yes	No
Shortness of Breath	Yes	No
Swelling of Ankles	Yes	No
Do you take blood thinners?	Yes	No
Do you take Aspirin, Naprosin or Advil?	Yes	No
Respiratory		
Chronic Cough	Yes	No
Coughing up Blood	Yes	No
Wheezing	Yes	No
Skin		
Rash	Yes	No
Itch	Yes	No

Hematological		
Bleeding Tendency	Yes	No
Bruising Tendency	Yes	No
Anemia	Yes	No
Past Transfusion	Yes	No
Gastrointestinal		
Poor Appetite	Yes	No
Difficulty Swallowing	Yes	No
Heartburn	Yes	No
Nausea or Vomiting	Yes	No
Bloating	Yes	No
Belching	Yes	No
Regurgitation	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Abdominal Pain	Yes	No
Change in Bowel Habits	Yes	No
Rectal Bleeding	Yes	No
Black, Tarry Stool	Yes	No
Neurological		
Headaches	Yes	No
Seizures	Yes	No
Strokes	Yes	No
Numbness	Yes	No
Psychiatric		
Memory Loss/ Confusion	Yes	No
Depression	Yes	No
Endocrine		
Heat or Cold Intolerance	Yes	No
Excessive Thirst/ Urination	Yes	No
Diabetic	Yes	No

Patient's Signature: _____

Ronald J. Boisen, M.D.
Daryl M. McClendon, M.D.
Jeffrey W. Molloy, M.D.

Your Right to Privacy

We respect your right to privacy regarding medical information. May we share information with your spouse?

If so, their Name: _____Contact Number: _____

We understand that you may have concerned relatives. Please list names of adult children, other family members and/or contact persons with whom we may share information without additional written consent:

Name / Relationship / Contact Number:	
Name / Relationship / Contact Number:	
Name / Relationship / Contact Number:	
Name / Relationship / Contact Number:	

Additional Information you wish to share: _____

I authorize RONALD J. BOISEN, M.D., DARYL M. MCCLENDON, M.D., and/or JEFFREY W. MOLLOY, M.D. to access my electronic prescription records for continued care and further treatment. Initials: _____

The following facilities (PAMC, ARH, and/or Alaska Digestive Center) are hereby authorized to review/access my Alaska Digestive and Liver Disease medical record, treatment record and diagnostic record. Initials:_____

I Acknowledge and agree that I have received a copy of RONALD J. BOISEN, M.D., DARYL M. MCCLENDON, M.D., and/or JEFFREY W. MOLLOY, M.D. notice of Privacy Practices.

I have read, acknowledged and agree to the terms above.

Printed Name: _____

Signature / Name: _____Date: _____

Patient legal Representative (if applicable): _____

Name of Representative: _____

Relationship to Patient: _____

Power of Attorney

Definition: A legal document giving a person the power to make decisions for another person, (e.g. current medical decisions, financial decisions).

Do you have a power of attorney on file? Yes / No
Name of person who holds the Power of Attorney: _____ Phone: _____

I have read, acknowledged and agree to the terms above.

Patient's Signature: _____ Date: _____

Appointment and Procedure Cancellation Policy

I understand that RONALD J. BOISEN, M.D., DARYL M. MCCLENDON, M.D., and JEFFREY W. MOLLOY, M.D. reserve the right to the following in the event that you need to reschedule:

- $25.00 Charge for cancelled **office visit** without giving at least one (1) business days' notice.

- $50.00 Charge for cancelled **procedures** without giving at least two (2) business days' notice.

This allows other patients to be scheduled into the appointment slot and for you to be efficiently rescheduled.

I have read, acknowledged and agree to the terms above.

Patient's Signature: _____Date: _____

Ronald J. Boisen, M.D.
Daryl M. McClendon, M.D.
Jeffrey W. Molloy, M.D.

Medicare Long Term Authorization

Name: _____ Medicare #:_____

I request that payment of authorized Medicare Benefits be made on my behalf for any service furnished to me by Ronald J. Boisen, M.D., Daryl M. McClendon, M.D., and/or Jeffrey W. Molloy, M.D. I authorize any holder of medical or other information about me be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits for related services.

Signature / Name: _____Date:_____

(Authorization good for one year from the above date)

PHONE MESSAGE CONSENT FORM

I _____ acknowledge and agree that (**Alaska Digestive and Liver Disease**) and any affiliates or vendor thereof, including collection or billing companies, may contact me by email, telephone or text message to any telephonic number or email address I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify (**Alaska Digestive and Liver Disease**) if I have given up ownership or control of any such telephone number.

My cell phone: (_____) _____-_____ Approved to leave message: Y/N_____

My home answering machine: (_____) _____-_____ Approved to leave message: Y/N_____

My office/work voice mail: (_____) _____-_____ EXT: _____

Other: (_____) _____-_____ EXT: _____

Other: (_____) _____-_____ EXT: _____

Other: (_____) _____-_____ EXT: _____

Email Address: _____

_____ _____

Patient/Guardian Signature: Date:

A. Notifier: Alaska Digestive and Liver Disease

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

Advanced Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. Office Visit** 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. Office Visit** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Office Visit	Not indicated for diagnosis and/or treatment in this case	No More than $600

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. Office Visit** 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. Office Visit** 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. Office Visit** 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. Office Visit** 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 understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Ronald J. Boisen, M.D.
Daryl M. McClendon, M.D.
Jeffrey W. Molloy, M.D.

Consent to Release and Disclose Protected Health Information

I, _____ the patient, D.O.B. _____ Phone #_____
Herby Authorize: _____

To release my health information as identified below for the following purpose (s):

___ Continuation of Care ___ Other: _____

___ Second Opinion ___ Personal Use

<u>Information to be disclosed</u>

Please check all appropriate boxes:

___ Summary of Medical History/Treatment

___ Laboratory/Diagnostic Tests

___ Radiology Records

___ All records, including any records in these subject areas:

- ___ HIV/AIDS
- ___ Sexually transmitted disease
- ___ Mental Illness or mental health treatment
- ___ Drug and alcohol abuse/treatment

___ Other _____

Person/Organization TO Receive Information

Name of person(s)/Organizations	Complete Address/Phone

The staff may discuss my medical condition and treatment with those person(s) listed above. This consent is subject to revocation at any time except to the extent that the persons/organization which is to make the disclosure has already taken action in reliance on it.

Re-Disclosure Prohibited: This information has been disclosed from records whose confidentiality's protected by state or federal law (42CFR part 2). These laws prohibit making any further disclosure of this information without the specific written consent of the person whom t pertains, or as otherwise permitted by law.

I Understand I may revoke this consent at any time. This consent expires on _____ or in 180 days unless otherwise specified.

Signature / Name: _____Date: _____

Witness/Title: _____ Date: _____