GENERAL SURGERY
at NORTHPOINTE

Gail Strindberg M.D.
Northpointe Medical Park
Bldg. A Suite 205 (2376 N. 400 E.)
Tooele, UT 84074

435-882-8111 fax 435-882-2111

Dear Patient,

Your Primary Care Doctor has referred you to Dr. Gail Strindberg for a screening colonoscopy. These are the forms that we will need for you to please fill out and return to our office. You may drop off the paperwork Monday through Friday from 8:30 am-11:30 am, and 1:00 pm-4:30 pm. When you bring them in we will also need to copy your Insurance card/s and a photo ID. At this time we will schedule your colonoscopy which can be performed on Tuesday's or Thursday's. We will also go over all the instructions that you need to prepare for the test. If you have any questions or concerns please give our office a call at 435-882-8111.

Sincerely,

Gail Strindberg

Dr. Gail Strindberg and Staff

GENERAL SURGERY AT NORTHPOINTE, LLC

PATIENT REGISTRATION FORM

Patient Information

Date _____ Home Phone (_____)_____ Cell Phone (_____)_____

Name _____ E-Mail Address _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Date of Birth _____ Race _____

Responsible Party (if patient is a minor) _____ Relationship to Patient _____

In case of emergency who should we notify?

Name: _____ Phone_____

Primary Insurance

Ins Company _____ Policy Number _____ Group Number _____

Policy Holder _____ Date of Birth _____
Last Name First Name

Relationship to Patient _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Ins Company_____ Policy Number_____ Group Number _____

Policy Holder _____ Date of Birth _____
Last Name First Name

Assignment and Release

I, the undersigned certify that I (for my dependent) assign all insurance benefits to General Surgery at Northpointe, LLC if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the name facility to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____ _____
Patient/Responsible Party Signature Relationship Date

GENERAL SURGERY AT NORTHPOINTE COLONOSCOPY SCREENING FORM

History and Physical

All areas of this form MUST be completed 100% before submission.

PATIENT NAME:_____

REFERRING PHYSICIAN:_____

DATE OF BIRTH:_____ ARE YOU 50 YRS OR OLDER: Yes_____ No_____

WEIGHT:_____ Height:_____ SEX: M F

REASON FOR PROCEDURE:

Have you had a colonoscopy previously: Yes_____, No ____

If you answered yes please give the date your last colonoscopy was performed: _____

If Yes, Were polyps found: Yes _____ No_____

SCREENING: Yes_____ No_____

Do you have a personal history of any of the following?

Polyps_____, Colon Cancer _____, Crohn's _____, Ulcerative colitis _____, NA_____

Do you have a family history of any of the following?

Polyps_____, Colon Cancer _____, Crohn's _____, Ulcerative Colitis _____, NA_____

Have you had any abdominal surgeries? Yes_____, No_____ If yes please list type & date:

_____

_____

_____

History and Physical Continued

Check the box if you ever had or you currently have any of the following:

- Asthma, Tuberculosis, emphysema or other lung problems
- Chest pain, irregular heartbeat, CHF, heart attack, murmur, other heart trouble
- Numbness, muscle weakness, dizziness
- Kidney trouble or blood in your urine
- Tendency to bleed or bruise easily
- Dentures or loose Teeth
- Contacts or hearing aids
- Sleep apnea
- Diabetes
- High blood pressure
- Convulsions, seizures, epilepsy
- Back problems
- Hepatitis or jaundice
- History of cancer or currently have cancer
- Use tobacco
- Use alcohol
- Women, are you or could you be pregnant

Are you taking any medications? Yes____ No_____
If yes, please list **ALL** medications that you are currently taking :

_____
_____
_____
_____
_____

Please list a local pharmacy you would prefer to use:_____

Are you allergic to anything? Yes___ No___
If yes, please list **ALL** allergies _____
_____

_____
Patient/Responsible Party Signature

General Surgery at Northpointe, LLC

General Consent for test, treatment, photo, video and services

I consent to examinations, blood tests (including blood test for communicable diseases such as hepatitis and HIV/Aids when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physician(s), fellow(s), resident(s), intern(s), and their associates and assistants, or rendered by facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s), or intern(s).

I agree and understand that all physicians (including fellows, residents, and inters), dentists, oral surgeons, and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions, and the facility is not responsible or liable for the acts or omission of the aforementioned. Service may be performed by independent contractors who are not employed by the facility. I am aware that the practice of medicine is not an exact science; and further understand that no guarantee has been or can be made as to the results of the treatments, care or examination in the facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the facility. I understand that one or more physicians, fellows, residents, and/or interns at the facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physician and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

I consent to the photography pr videotaping, including appropriate portions of my body, for medical and medical records documentations purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

The undersigned certifies that s/he had read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative Date Time

Relationship to Patient Interpreter, if utilized

Witness Signature If Telephone Consent, 2nd Witness Signature

General Surgery at Northpointe, LLC

Financial Agreement Form

Thank you for choosing us as your health care facility. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical treatment. All patients must also complete the medical history and insurance form before being seen. The content of this document may not be changed.

RELEASE OF INFORMATION: I agree that General Surgery at Northpointe, LLC (GSNP) may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices. This includes appropriate release and disclosure of my medical records in compliance with privacy provisions when necessary for my treatment and general health. While receiving treatment and/or care, GSNP has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present, my personal health information will not be disclosed unless I agree to disclosure.

FINANCIAL AGREEMENT: Payment of all insurance co-payments, co-insurance and deductibles are required at the time of service. Patients who have no insurance are required to pay 100% of service at the time of service. If this is impossible you will need to make payment arrangements with our office prior to any medical service. We accept cash, checks and major credit cards.

TERMS: Net 30 days from date of **invoice** unless otherwise indicated above. (If applicable, GSNP will not invoice patients until payment from insurances are received).

- Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1.75% per month (21% annual rate) will be charged to the amount not paid after 30 days, with a minimum charge of $.50 per month.
- A $25.00 fee will be charged on all returned checks
- The undersigned specifically agrees to pay all reasonable attorney fees and court cost in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the amount is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

ASSIGNMENT OF INSURANCE BENEFITS: You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. **Any service provided, but not covered by your insurance company, will be your responsibility to pay.** Your insurance policy is a contract between you and your insurance company. We are not party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim. I authorize direct payment to GSNP of any insurance benefit. I agree to pay any unpaid balances on my account no more than 30 days after date of service.

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and a durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore in accordance with Federal law, GSNP is notifying you that it will NOT HONOR previously signed advanced directives. If this is not acceptable to you, you must address this issue with our management prior to performing the procedure.

HIPAA PRIVACY NOTICE: I acknowledge that I have received GSNP's HIPAA PRIVACY notice and have had the opportunity to review its content. _____ (please initial)

I certify that I have read this document, and am the patient, or am duly authorized to execute it and accept its terms.

_____ _____

Patient/Responsible Party Signature Date