GENERAL SURGERY
at NORTHPOINTE
Northpointe Medical Park Bldg. A Suite 205
Gail Strindberg, MD
|2376 N 400 E Ste 205|Tooele, UT 84074|
|Phone: 435-882-8111|Fax: 435-882-2111|

Dear Patient,

It's time for you to have a colonoscopy or your primary care provider has referred you to schedule one.

Please complete all forms included with this letter and bring them to our office, in person:

Monday - Thursday between: 8:30 am - 11:30 am & 1:30 pm - 4:30 pm.

When you bring in your completed forms, also bring a picture ID and your insurance card(s). At that time, we'll add you to our surgery schedule which will be either a Tuesday or Thursday. We will also instruct you on how to prepare for your colonoscopy.

Please be aware, your colonoscopy may not be covered at 100%, you may receive a separate bill from:

1. General Surgery at Northpointe (our office **Gail Strindberg, MD**)
2. Northpointe Surgical Center
3. Deseret Peak Anesthesia
4. Pathology

If you have any questions or concerns, please call us at (435) 882-8111.

Sincerely,

Dr. Gail Strindberg & Staff

# GENERAL SURGERY AT NORTHPOINTE
# COLONOSCOPY SCREENING FORM

**History & Physical**

**All areas on this form MUST be completed 100% before submission**

Date: _____

Patient Name: _____

Referring Provider: _____

Date of Birth: _____ Are you 45 Years or older? Yes_____ No_____

Weight: _____ Height: _____

**REASON FOR PROCEDURE:**

Have you had a colonoscopy previously: Yes _____ No _____

If yes, please give the date and where your last colonoscopy was performed:

_____

If yes, were polyps found: Yes _____ No _____

If yes, was it a screening: Yes _____ No _____

**Do you have a <u>PERSONAL</u> history of any of the following?**

Polyps_____ Colon Cancer _____Crohn's Disease _____ Ulcerative colitis _____ NA _____

**Do you have any <u>FAMILY</u> history of any of the following?**

Polyps_____ Colon Cancer _____Crohn's Disease _____ Ulcerative colitis _____ NA _____

Have you had any abdominal surgeries? Yes _____ No _____ If yes, please list type & date:

# GENERAL SURGERY AT NORTHPOINTE COLONOSCOPY SCREENING FORM

**History & Physical Continued**

Patient Name: _____ Date of Birth: _____

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

- ☐ Asthma
- ☐ Back Problems
- ☐ Blood In Your Urine
- ☐ Chest Pain
- ☐ CHF
- ☐ Contacts
- ☐ Convulsions
- ☐ Currently have Cancer
  If yes, type: _____
- ☐ Dentures or Loose Teeth
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Hearing Aids
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ History of Cancer,
  if yes, type: _____
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Kidney Trouble
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Other Heart Trouble
- ☐ Other Lung Problems
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Tendency to Bleed or Bruise Easily
- ☐ Tuberculosis
- ☐ Use Alcohol
- ☐ Use Tobacco
- ☐ Women: Are you or could you be pregnant

Please list **ALL** medication with dosage, that you are currently taking, including any over the counter medicine and vitamins.

_____

_____

_____

_____

If you do not take any medication, please check box. ☐

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
# PATIENT REGISTRATION FORM

## Patient Information

Date: _____ Home Phone: (____)_____ Cell Phone: (____)_____

Name: _____ E-mail: _____
Last Name First Name Middle Initial

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

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

Responsible Party (If patient is a minor): _____

Relationship to Patient: _____

In case of an emergency who should we notify?

Name: _____ Phone: _____

⇨ (Relationship to patient) _____

## Primary Insurance - Yes No

**Please provide copy of card**

**Name of Primary Insurance:** _____

**If your insurance ID isn't listed on your card, please provide:** _____

## Secondary Insurance - Yes No

**Please provide copy of card**

**Name of Secondary Insurance:** _____

**If your insurance ID isn't listed on your card, please provide:** _____

## Assignment and Release

I, the undersigned certify that I (or 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 they are paid by insurance or not. I hereby authorize the name facility to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____ _____
Patient/Responsible Party Signature Relationship Date

# *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(s), fellow(s), resident(s) or intern(s).

I agree and understand that all physicians (including fellows, residents and interns) dentists, oral surgeons and podiatrists involved in my care in any way are 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 or 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 or video recording, including appropriate portions or my body, for medical and medical records documentations purposes, provided said photographs or video recordings are maintained and released in accordance with protected health information regulations (HIPAA).

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The undersigned certifies that she/he has read the forgoing, 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 (GSN) 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 carrier, 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, GSN 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 no present, my personal health information will not be disclosed unless I agree to disclosure.

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

**TERMS:** Net 30 days from date of invoice unless otherwise indicated above. (If applicable, GSN will not invoice the patient until payment(s) 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 **$65.00** fee will be charged on all returned checks.
- The undersigned specifically agrees to pay all reasonable attorney fees and court costs 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 charges 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 GSN 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 REQUESTS:** 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 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 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, GSN 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 preforming the procedure.

**CANCELLATION/NO SHOW FEES:** I acknowledge and understand, that if I do not show for an appointment or cancel within 24 hours of my scheduled appointment, I will be charged a $50.00 fee, that is not covered by insurance and will be paid personally by myself/responsible party.

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

_____ _____

Patient/Responsible Party (Print Name) Relationship to Patient (Self, Parent, etc.)

_____ _____

Signature of Patient/Responsible Party Date

# *General Surgery at Northpointe, LLC*

## HIPAA Compliance Patient Consent Form

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

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

**By signing this form, I understand that:**

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Name the member(s) allowed, to discuss your medical condition/billing:

| Name | Relationship to patient | Phone Number | Medical/Billing or both |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

If other than patient, please state relationship to patient: _____

Signature: _____ Date: _____