EVGHA

East Valley Gastroenterology & Hepatology Associates
And Chandler Endoscopy Center
480-786-6655

A PATIENT’S BILL OF RIGHTS

It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes a new dimension when care is rendered within an organizational structure. Legal precedent has established that the facility itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The Patient has the right to know the Chandler Endoscopy Center is physician owned and operated by Dr. Singh, Dr. Levy, Dr. Khosla, Dr. Lowe and Dr. Davis.

2. The patient has the right to be treated with consideration, dignity and respect; without being subjected to reprisal or discrimination.

3. The patient has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his/her behalf. He/she has the right to know, by name, the physician responsible for coordinating his/her care.

4. The patient has the right to participate in decisions involving in his/her care and to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternative, the patient has the right to know the name of the person responsible for the procedures and/or treatment.

5. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.

6. The patient has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discretely. Those not directly involved in his/her care must have permission of the patient to be present.

7. The patient has the right to expect that all communications and records pertaining to his/her care, including financial records, should be treated as confidential and not released without written authorization by the patient.

8. The patient has the right to expect that within its capacity, this ambulatory endoscopy facility must provide evaluation, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

9. The patient has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him/her.

10. The patient has the right to be advised if this ambulatory endoscopy facility proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.

11. The patient has the right to expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby his/her physician of his/her continuing health care requirements following discharge informs him.

12. The patient has the right to examine and receive an explanation of his/her financial obligation regardless of the source of payment and to be informed regarding the fees for procedures performed at the Center. The patient has the right to be informed of third party coverage including Medicare and Arizona Health Care Cost Containment System.

13. The patient has the right to know what facility rules and regulations apply to his/her conduct as a patient.

14. The patient has a right to request information about the grievance process at the center. If a patient has a grievance with the center, he/she has the right to speak immediately with the Clinical Director or the substitute person assigned to answer to grievances. A formal written grievance may be completed for further review of the grievance.

15. The patient has a right to be free from chemical, physical and psychological abuse or neglect.

16. The patient has the right to know if a patient is judged incompetent there must be a court ordered representative.

17. The patient has a right to know Chandler Endoscopy Center does not honor Advanced Directive. The website is www.azag.gov.

18. The patient has the right to exercise his/her rights without being subjected to discrimination or reprisal.

19. The patient has the right to know the website address and phone number to the Arizona Department of Health Services. In the event they wish to speak to a representative about a concern or complaint. The website is www.dhhs.gov. The phone number is 602-364-3030. The address is 150 N. 18th Ave., Phoenix, AZ 85007. In addition patients under Medicare may contact the Office of Medicare Beneficiary Ombudsman at www.medicare.gov/Ombudsman/resources.asp

PATIENT RESPONSIBILITIES

It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur. The patient is expected to follow up on his/her doctor's instructions, take medication when prescribed, and ask a question concerning his/her own health care that he/she feels is necessary.

1. It is the Patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of these decisions if complications occur.

2. The Patient is expected to follow up on his/her doctor's instructions, take medication when prescribed, and ask a question concerning his/her own health care that he/she feels is necessary.

3. The Patient is expected to provide a responsible adult to stay in the facility during the entire procedure, transport the patient home, and stay with the patient for 24 hours after procedure if requested by the physician.

4. The Patient agrees to accept any, or all, financial responsibility not covered by insurance.

5. The Patient is expected to treat all health insurance providers and staff respectfully.

Date: ________________________ Patient Signature: ________________________ Witness: ________________________
It is the patient’s responsibility to know your insurance benefits and policy requirements for office visits and procedures. Initial

It is the patient’s responsibility to bring your current insurance card and method of payment for each visit or procedure. Also to update your current address and contact information for our records. Failure to do so may result in discontinuation of medical care. Initial

It is the patient’s responsibility to keep follow up appointments as scheduled. Failure to show up for appointments or procedures can result in delay of abnormal lab studies, imaging studies, and biopsy results. It also can result in the delay in diagnosis or missing serious conditions including cancer, which can be detrimental to your health. It is your responsibility to reschedule appointments for continuation of care. Failure to keep two consecutive appointments, no shows for procedures, and accounts no longer maintained in good faith status may result in termination of provider-patient relationship with East Valley Gastroenterology and Hepatology Associates P.C. Initial

If you have any questions regarding your care or need any help you can talk to your M.D., their M.A., or the office manager. If for any reason you are still not satisfied make an appointment and have all your questions answered. Initial

I understand health information that is collected about me will be kept confidential in our facilities. Initials

I have had the opportunity to review the CEC Bill of Rights and Policy on Advance Directives. I also understand that it is operated by the following physicians: Dr. Singh, Dr. Levy, Dr. Khosla, Dr. Lowe, Dr. Davis, and Dr. Panossian. Initial

These forms can be found on our website, www.eastvalleygastro.com. I understand if I request a copy of these documents, it can be provided to me immediately.

______________________________  __________________________
Patient’s Signature                        Date
I understand that if I have medical insurance it will be billed on my behalf. These claims may consist of office visits, procedural charges, and/or Pathology Services. Initial

I understand that it is my responsibility to pay all co-pays, deductibles, co-insurances, and uncovered services within thirty days after my insurance has paid their portion. Initial

I thereby assign all medical benefits directly to East Valley Gastroenterology and Hepatology PC and Premier Endoscopy Center LLC. Initial

Release of Information Form
(This is for family members and any doctors other than your Primary Care Physician)

I, ____________________, authorize the release of my personal healthcare information to the following individuals:

1. ___________________________ Relationship: ____________
2. ___________________________ Relationship: ____________
3. ___________________________ Relationship: ____________
4. ___________________________ Relationship: ____________

_________________________________________  ____________________________
Patient Signature                                       Date
**EAST VALLEY GASTROENTEROLOGY & HEPATOLOGY ASSOCIATES, P.C.**

**MEDICAL HISTORY**

<table>
<thead>
<tr>
<th><strong>HISTORY OF PRESENT ILLNESS</strong></th>
<th><strong>Duration of symptoms</strong></th>
<th><strong>Quality of Pain</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Nausea</td>
<td>□ Days</td>
<td>□ Burning</td>
</tr>
<tr>
<td>□ Vomiting</td>
<td>□ Weeks</td>
<td>□ Stabbing</td>
</tr>
<tr>
<td>□ Upper abdominal pain</td>
<td>□ Months</td>
<td>□ Annoying</td>
</tr>
<tr>
<td>□ Lower abdominal pain</td>
<td>□ Years</td>
<td>□ Sharp</td>
</tr>
<tr>
<td>□ Bloating</td>
<td></td>
<td>□ Dull</td>
</tr>
<tr>
<td>□ Indigestion</td>
<td></td>
<td>□ Knot</td>
</tr>
<tr>
<td>□ Heartburn- acid reflux</td>
<td></td>
<td>□ Cramping</td>
</tr>
<tr>
<td>□ Food sticking to chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Chest pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yellow jaundice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Weight loss #____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Loss of appetite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Intolerance to foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Constipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Change in bowel habits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Rectal bleed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Black stools</td>
<td>□ Pelvic lower</td>
<td></td>
</tr>
<tr>
<td>□ BM frequency/day#___</td>
<td>□ Right flank</td>
<td></td>
</tr>
<tr>
<td>□ BM frequency/week#___</td>
<td>□ Left flank</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Periumbilical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ All over</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No Current Symptoms</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>LOCATION OF PAIN</strong></th>
<th>□ Left upper abdomen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Right upper abdomen</td>
</tr>
<tr>
<td></td>
<td>□ Mid upper abdomen</td>
</tr>
<tr>
<td></td>
<td>□ Right lower abdomen</td>
</tr>
<tr>
<td></td>
<td>□ Left lower abdomen</td>
</tr>
<tr>
<td></td>
<td>□ Pelvic lower</td>
</tr>
<tr>
<td></td>
<td>□ Right flank</td>
</tr>
<tr>
<td></td>
<td>□ Left flank</td>
</tr>
<tr>
<td></td>
<td>□ Periumbilical</td>
</tr>
<tr>
<td></td>
<td>□ No Current Symptoms</td>
</tr>
</tbody>
</table>

**PAST MEDICAL HISTORY**

<table>
<thead>
<tr>
<th></th>
<th>□ Asthma</th>
<th>□ Colon Polyps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Blood Clot in Lung</td>
<td>□ Hemorrhoids</td>
</tr>
<tr>
<td></td>
<td>□ Pneumonia</td>
<td>□ Pancreatitis</td>
</tr>
<tr>
<td></td>
<td>□ Emphysema</td>
<td>□ Gallstones</td>
</tr>
<tr>
<td></td>
<td>□ COPD</td>
<td>□ Hepatitis_____</td>
</tr>
<tr>
<td></td>
<td>□ Sleep Apnea</td>
<td>□ Liver Disease</td>
</tr>
<tr>
<td></td>
<td>□ Prostate Problems</td>
<td>□ Liver Cirrhosis</td>
</tr>
<tr>
<td></td>
<td>□ Kidney Stones</td>
<td>□ Stroke</td>
</tr>
<tr>
<td></td>
<td>□ Kidney Disease</td>
<td>□ Seizure</td>
</tr>
<tr>
<td></td>
<td>□ Acid Reflux</td>
<td>□ Migraines</td>
</tr>
<tr>
<td></td>
<td>□ Stomach Ulcers</td>
<td>□ Depression</td>
</tr>
<tr>
<td></td>
<td>□ Diverticulosis</td>
<td>□ Alzheimer’s Disease</td>
</tr>
<tr>
<td></td>
<td>□ Irritable Bowel Syndrome</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Crohn’s Disease</td>
<td>□ Alcoholism</td>
</tr>
<tr>
<td></td>
<td>□ Ulcerative Colitis</td>
<td>□ Drug Abuse</td>
</tr>
<tr>
<td></td>
<td>□ None</td>
<td></td>
</tr>
</tbody>
</table>
PLEASE PRINT CLEARLY
(Include herbal/vitamin supplements and over the counter medications)

Do you take:
Coumadin/Warfarin     Yes    No
Aspirin               Yes    No    (If yes: 81mg or 325mg)
Iron Supplements      Yes    No

Medication Name:    Dosage:    Frequency:
1. ___________________  2. ___________________  3. ___________________
4. ___________________  5. ___________________  6. ___________________
7. ___________________  8. ___________________
9. ___________________  10. ___________________
11. ___________________ 12. ___________________
13. ___________________ 14. ___________________
15. ___________________ 16. ___________________
17. ___________________ 18. ___________________
19. ___________________ 20. ___________________

ALLERGIES and REACTION--  □ No Known Drug Allergies
1. ________________  2. ________________  3. ________________
4. ________________  5. ________________  6. ________________

What pharmacy do you use?:
Name:    Address/Intersection:    Phone#:
**PAST SURGICAL HISTORY**

- Adhesion
- Aortic Aneurysm
- Appendix Removal
- Back-Spinal
- Brain
- Colon (surgery)
- Esophagus (surgery)
- Gallbladder
- Heart Bypass
- Heart Valve
- Hemorrhoidectomy
- Hysterectomy-ovaries
- Joint Replacement
- Prostate
- Stomach
- Transplant
- Ulcer
- Weight Loss (surgery)
- None
- Other: ______________

**Anesthesia Complications**

- No
- Yes: ______________

**Surgical Complications**

- No
- Yes: ______________

**FAMILY HISTORY**

- Celiac Sprue
- Colon Cancer
- (Who?) __________
- Crohn's Disease
- Esophageal Cancer
- Pancreatic Cancer
- Stomach Cancer
- Liver Disease
- Pancreatitis
- Ulcerative Colitis

**SOCIAL HISTORY**

- Current Smoker
  - how long: _________
- Former Smoker
- Never Smoked

**Alcohol use:**

- None
- 1-2 drinks per week
- 3-5 drinks per week
- 6 or more per week

**Caffeine Use:**

- Occasional
- Frequent
- None

**Drug Use (Illegal):**

- Yes
- No

**HIV/High Risk**

- Yes
- No

**Regular Exercise**

- Yes
- No

---

**REVIEW OF SYSTEMS**

- Fatigue
- Fever
- Sweats
- Chills
- Rash
- Itching
- Easy Bruising
- Change in vision
- Dizziness
- Change in voice
- Sore Throat
- Ears Ringing
- Nose Bleeds
- Wheezing
- Short of Breath
- Feet Swelling
- Poor Circulation
- Rapid heartbeat
- Cough
- Phlegm
- Urine Burning
- Blood in urine
- Frequent urine
- Muscle aches
- Joint Pain
- Bone-spine pain
- Headaches
- Leg cramps
- Increased stress
- Imbalance
- Lightheadedness
- Loss of interest
- Can't Concentrate
- Oversleeping
- Can't Sleep
- Agitation
- Confusion
- Depression
- Suicide thoughts
- Panic attacks
- Anxiety
- Numbness
- None of the above

Females: Could you possibly be pregnant right now?  YES  NO  UNSURE

When was your last menstrual cycle? Approx. ______________