Patient Demographic Form

Legal Last Name	Legal First Name	Middle Name

Social Security Number (VA and Tri-Care Patients Only)	Date of Birth	Gender: ☐ Male ☐ Female ☐ Other

Address		
City	State	Zip

What is Your Race? (Check one or more)

☐ Alaskan Native ☐ Asian ☐ Black/African American ☐ Multi-Racial

☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Other _____

Primary Language	Hispanic Origin? ☐ Yes ☐ No	Marital Status:	Medical Providers involved in my care:

Home Phone #	May Leave a Message ☐ Yes ☐ No	Preferred Pharmacy and Location:	
Cell Phone #	May Leave a Message ☐ Yes ☐ No	Employer	Employer Phone
Would you like to receive automated appointment reminders? ☐ Yes ☐ No		Preferred method to receive appointment reminders? ☐ Voice Message ☐ SMS Text	
Spouse Name	Spouse DOB	Emergency Contact Name	Relationship / Phone #

Alaska Digestive and Liver Disease has a secure and confidential Internet-based portal to enhance communication with our clients. You can use the portal to review your medication, check your latest test results, request prescription refills, and more – 24 hours a day. By providing your email, you are consenting to receive email communications from Alaska Digestive and Liver Disease.

Email Address_____@_____

PRIMARY INSURANCE

Primary Insurance Name	ID Number	Group Number

Policy Holder's Name	Relationship of Policy Holder to you:
Medical Claims Submission Address	Policy Holder's Date of Birth

SECONDARY INSURANCE

Secondary Insurance Name	ID Number	Group Number

Policy Holder's Name	Relationship of Policy Holder to you:
Medical Claims Submission Address	Policy Holder's Date of Birth

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

☐ I authorize Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D.,Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP to administer medical treatment.

☐ I authorize Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP at 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) to pay benefits directly to Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D., Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP 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 Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D, Austin T. Nelson, M.D., Martin P. Kaszubowski, M.D., and/or Terri L. Tope ANP 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:** _____

ALASKA DIGESTIVE & LIVER DISEASE

Patient Medical History Form

Name:_____ DOB:_____ Date:_____

REASON FOR VISIT: _____

CURRENT MEDICATIONS *if you are providing your own list, circle here: MY MED LIST

Medication Name	Dose	Frequency
1.		
2.		
3.		
4.		

Are you taking any Blood Thinning medications, i.e. Coumadin____Warfarin____Plavix____Xarelto____Effient____Pradaxa____ Eliquis____ Aspirin____ Pletal____ Savaysa____ Other_____

INFECTION HISTORY *Circle if you currently have or have had:

Hepatitis		HIV/AIDS		MRSA		C.DIFF		TB	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Have you had vaccinations, specify year: Tetanus/T-Dap: _____ Flu:_____ Hepatitis B:_____ Pneumonia:_____ Shingles:_____

CHRONIC ILLNESSES *Circle if you currently have or have had:

☐ Diabetes	☐ Myocardial Infraction	☐ Seizures
☐ Hypertension	☐ CABG/ Heart Bypass	☐ Crohn's Disease
☐ Heart Disease	☐ Pacemaker/ Defibrillator	☐ Ulcerative Colitis
☐ Cardiac Stents	☐ Sleep Apnea (CPAP)	☐ Reflux
☐ Heart Arrhythmia	☐ Anemia	☐ Blood Clots/ DVT
☐ COPD	☐ Pulmonary Embolus	☐ Asthma
☐ Blood Transfusion	Other:	Other:

Have You Ever Had?

☐ Colon Polyps
☐ Colonoscopy: Year_____
☐ Upper Endoscopy: Year_____
☐ Ulcers
☐ Liver Disease
☐ Pancreatitis
☐ Cancer ***Please Specify Type:_____**

ALLERGIES: Medications, Solutions or Metal

Medication, Solution or Metal Name	Allergic Reaction
1.	
2.	
3.	
4.	

PREVIOUS OPERATIONS/HOSPITALIZATIONS *Please list:

Type	Year	Reason
1.		
2.		
3.		
4.		

Have you ever had anesthesia complications? No Yes
Please describe if answered Yes: _____

FAMILY HISTORY

Please indicate Relationship (i.e. father): Do you know of any blood relatives who have or have had any of the following?

Crohn's or Ulcerative Colitis	Pancreatitis
Ulcer	Polyps
Liver Disease	Cancer (Specify Type)
Celiac Sprue	Other:

SOCIAL HISTORY

Tobacco Use?	**Drug Use?**	**Alcohol Use?**
☐ Smokeless	☐ Meth	☐ Do you drink
☐ E-Cigarettes	☐ Cocaine	☐ Drinks Per Week_____
☐ Cigarettes (Packs/day) _____	☐ Marijuana	☐ Other_____
☐ Never Smoked	☐ IV Drugs	
☐ Former Smoker (Quit Date)_____	☐ Other_____	

REVIEW OF SYSTEMS * As you review the following list, please circle ALL which have significantly affected you:

GENERAL
Unexpected Weight Loss
Unexpected Weight Gain
Fever
Fatigue

EYES
Blurred/Double Vision
Glaucoma

EARS, NOSE & THROAT
Hearing Loss
Ringing in Ears
Mouth Sores

CARDIOVASCULAR
Chest Pain
Pacemaker/Defibrillator
Cardiac Valve Disease
Shortness of Breath
Swelling of Ankles
Blood Thinners
Taking Aspirin, Aleve or Advil

RESPIRATORY
Chronic Cough
Coughing up Blood
Wheezing

SKIN
Rash
Itching

HEMATOLOGICAL
Bleeding Tendency
Bruising Tendency
Anemia
Past Transfusion

GASTROINTESTINAL
Poor Appetite
Trouble Swallowing
Heartburn
Nausea
Vomiting
Bloating
Belching
Regurgitation
Constipation
Diarrhea
Abd. Pain
Change in Bowel Habits
Rectal Bleeding
Black Tarry Stool

NEUROLOGIC
Headaches
Seizures
Strokes
Numbness/Tingling

PSYCHIATRIC
Memory Loss
Confusion
Depression

ENDOCRINE
Excessive Thirst
Excessive Urination
Heat or Cold Intolerance
Diabetic

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:	

- □ I authorize Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP. to access my electronic prescription records for continued care and further treatment.
- □ 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.
- □ I Acknowledge and agree that I have access to print or read the notice of Privacy Practices for Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP

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

Printed Name: _____

Signature / Name: _____Date: _____

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: _____

Appointment and Procedure Cancellation Policy

I understand that Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP 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: _____

ALASKA DIGESTIVE & LIVER DISEASE

Medicare Secondary Payer Questionnaire

1. Are you receiving benefits from any of the following programs?

   Black Lung ___ No ___Yes

   Research Grant ___No ___Yes

   Veterans Affairs ___No ___Yes

   (**If yes to any of the above, STOP** – Medicare is secondary)

2. Was the illness/injury due to a work-related accident/condition?

   ___No _____Yes (**If yes, STOP** – Medicare is secondary)

3. Was illness/injury due to a non-work related accident?

   ____No _____Yes (**If yes, STOP** – Medicare is secondary)

4. Are you entitled to Medicare based on:

   _____Age _____Disability ____ End Stage Renal Disease

5. Do you have health insurance sponsored through your own or spouse's employer?

   _____No _____Yes (**If NO** – Proceed to question 7)

6. Does the employer that sponsors your insurance plan employ 100 or more employees?

   _____No _____Yes (**If yes, STOP** – Medicare is secondary)

7. Are you currently a patient in a skilled nursing facility (SNF) such as a nursing home?
   (If yes, we will bill SNF, not Medicare)

   ____ No _____Yes

I confirm that to the best of my knowledge, the above information is accurate.

Please Print Patient Name: _______________________

Patient Signature: _______________________ Date: _____________

- -

My initials below confirm that the above is still accurate as of the date indicated:

___________ ___________ ___________ ___________ ___________ ___________

___________ ___________ ___________ ___________ ___________ ___________

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._____** 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._____**below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
	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._____**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._____** 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. _____**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._____** 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.

Daryl M. McClendon, M.D.
Jeffrey W. Molloy, M.D.
Austin T. Nelson, M.D.
Martin P. Kaszubowski, M.D.
Terri L. Tope, ANP

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 Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., and/or Terri L. Tope, ANP. 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)