



Direct Access Colonoscopy Program

We are pleased that you have chosen ADLD as your Gastroenterology provider. You and your primary care provider have determined that you need a colonoscopy. Colonoscopy is a medical procedure during which a flexible tube is used to look inside the colon.

The Alaska Digestive and Liver Disease Clinic strives to provide compassionate and high quality medical care to patients. Please note that without a full consultation it is possible that there are gastrointestinal issues that may not be addressed in the direct access program. If you would rather see the gastroenterologist in consultation we will provide you with an appointment. For a direct access colonoscopy, you will not meet the gastroenterologist in person until the day of your procedure.

You have been identified as having minimal medical problems which do not require a consultation to review. We ask that you complete our patient packet and submit it prior to being scheduled for your procedure. After your information is received and reviewed, our office staff will call you to schedule your procedure and give you bowel preparation instructions.

Please note that some insurance carriers do not cover colonoscopy as a screening procedure for colorectal cancer. You should check with your insurance carrier to confirm coverage and benefits. We are happy to provide procedure and diagnosis codes at your request for you to provide to your insurance company. To assist us in providing you with the correct information please indicate why you are having a colonoscopy:

Patient signature: _____ Date: _____



Patient Demographic Form

Legal Last Name		Legal First Name		Middle Name
Social Security Number (VA and Tri-Care Patients Only)		Date of Birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Address				
City		State	Zip	
What is Your Race? (Check one or more) <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				
Primary Language	Hispanic Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status:	Medical Providers involved in my care:	
Home Phone #	May Leave a Message <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Pharmacy and Location:		
Cell Phone #	May Leave a Message <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer	Employer Phone	
Would you like to receive automated appointment reminders? <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred method to receive appointment reminders? <input type="checkbox"/> Voice Message <input type="checkbox"/> 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.				
<input type="checkbox"/> 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.				
<input type="checkbox"/> 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.				
<input type="checkbox"/> 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: _____	

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:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Myocardial Infraction	<input type="checkbox"/> Seizures
<input type="checkbox"/> Hypertension	<input type="checkbox"/> CABG/ Heart Bypass	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pacemaker/ Defibrillator	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Cardiac Stents	<input type="checkbox"/> Sleep Apnea (CPAP)	<input type="checkbox"/> Reflux
<input type="checkbox"/> Heart Arrhythmia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Clots/ DVT
<input type="checkbox"/> COPD	<input type="checkbox"/> Pulmonary Embolus	<input type="checkbox"/> Asthma
<input type="checkbox"/> 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.	



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:

- \$50.00 Charge for cancelled **office visit** without giving at least two (2) business days' notice.
- \$100.00 Charge for cancelled **procedures** without giving at least four (4) 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: _____



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.
<input type="checkbox"/> 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.
<input type="checkbox"/> 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.
<input type="checkbox"/> 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:
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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)