ADLD
ALASKA DIGESTIVE & LIVER DISEASE

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 / May Leave a Message □ Yes □ No
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 #

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:_____

PATIENT PORTAL

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

☐ 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 and 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 for, treatment and diagnostic record for coordination of care.

- **I acknowledge and agree to the terms above:**
- **Patient's Signature: _____ Today's Date:_____**

PATIENT MEDICAL HISTORY

NAME:_____ DATE OF BIRTH:_____/_____/_____

REASON FOR VISIT:_____ TODAY'S DATE:_____/_____/_____

MEDICATIONS: Please list the medications you are taking (prescription, over-the-counter, and supplements). Complete each column for dosage. Attach additional pages if needed.

Medication Name:	Dosage:	How often are you taking?
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed

Are you on any blood thinners (i.e. Coumadin, Plavix, Xarelto, Eliquis, etc.) **□ Yes □ No**

ALLERGIES:

If you have experienced allergies to any of the following, please select the box

□ None	□ Latex
□ Antibiotics *(please specify)*	□ Other
□ X-ray/ Radiology Contrast	□ Other

PAST MEDICAL HISTORY:

Have you EVER experienced any of the following? *If the answer is yes, please select the box.*

□ Anemia	□ Heart Attack	□ Irritable Bowel Syndrome
□ Anxiety Disorder	□ Heart Failure	□ Kidney Disease
□ Artificial Joints	□ Heart Stents	□ Liver Disease
□ Asthma	□ Heart Valve Replacement	□ MRSA
□ Acid Reflux	□ Heart Bypass Surgery	□ Pacemaker
□ Bleeding Disorder	□ Hepatitis	□ Pancreatitis
□ Clostridium Difficile	□ Hiatal Hernia	□ Seizure Disorder
□ Colon/ Rectal Cancer	□ High Blood Pressure	□ Sleep Disorder
□ COPD/Emphysema □ On Oxygen	□ High Cholesterol	□ Stomach Cancer
□ Crohn's Disease	□ History of Tuberculosis	□ Stroke
□ Diabetes	□ History of Blood Clots	□ Thyroid Disorders
□ Diverticulosis	□ HIV Infection	□ Ulcerative Colitis
□ Diverticulitis	□ Implantable Defibrillator	□

PAST SURGICAL HISTORY:

Have you had any of the following surgeries? If the answer is yes, please select the box

□ Appendix Removal	□ Heart Surgery	□ Portion of Bowel Removed
□ Gallbladder Removal	□ Hysterectomy	□ Stomach Surgery
□ Weight Loss Surgery	□ Other:	□ Other:

PAST ENDOSCOPIC HISTORY:

Type of endoscopy:	When:	Did they find Polyps:
□ Colonoscopy		□ Yes □ No
□ EGD/ Upper Endoscopy		

Have you had a problem with sedation or anesthesia? (describe) _____

_____

SOCIAL HISTORY

Smoking/ Tobacco/Nicotine Use:

Have you ever smoked or used tobacco/ nicotine products? □ Yes □ No Used for how many years:_____When did you quit?: _____
Cigarettes: □ Currently use □ Formerly used Cigarettes per day: _____ Cigars: □ Currently use □ Formerly used Pipe: □ Currently use □ Formerly used Nicotine Patch: □ Currently use □ Formerly used Vape: □ Currently use □ Formerly used Chew Tobacco: □ Currently use □ Formerly used

Alcohol Use:

Do you drink alcohol now? □ Yes □ No Have you drank alcohol in the past? □ Yes □ No How much per week: □ beer _____ □ wine_____ □ liquor _____

Recreational Drug Use:

Have you ever used recreational or IV drugs? □ Yes □ No Marijuana? □ Yes □ No Ongoing Use: □ Yes □ No
Form of use: □ Smoking □ Snorting □ IV □ Oral ingestion

FAMILY HISTORY

Have your blood relatives had any of the following? *If yes, please select the box for their relation to you.*

Colon Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Colon Polyps	□ Mother	□ Father	□ Sibling	□ Grandparent
Esophageal Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Crohn's Disease	□ Mother	□ Father	□ Sibling	□ Grandparent
Liver Disease	□ Mother	□ Father	□ Sibling	□ Grandparent
Pancreatic Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Stomach Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Ulcerative Colitis	□ Mother	□ Father	□ Sibling	□ Grandparent
Gallbladder Problems	□ Mother	□ Father	□ Sibling	□ Grandparent
Celiac Disease	□ Mother	□ Father	□ Sibling	□ Grandparent

REVIEW OF SYSTEMS:

Do you CURRENTLY have any of the following? If the answer is yes, select the box:

General:
□ Weight Loss
□ Fatigue
□ Poor Appetite

Heart:
□ Chest Pain
□ Shortness of Breath

Lungs:
□ Chronic Cough
□ Coughing up Blood

Skin:
□ Rash
□ Itching

Endocrine
□ Excessive Thirst
□ Excessive Urination
□ Heat or Cold Intolerance

Neurologic:
□ Memory Loss
□ Headaches

Mental Health:
□ Depression
□ Confusion

Ears, Nose and Throat:
□ Hearing Loss
□ Hoarseness
□ Mouth Sores
□ Blurred/Double Vision

Blood Systems:
□ Anemia
□ Bleeding Tendency

Immune System:
□ Asthma

Digestive System:
□ Abdominal Pain
□ Abdominal Bloating
□ Constipation
□ Heartburn
□ Belching
□ Regurgitation
□ Diarrhea
□ Passing Blood with Stool
□ Nausea
□ Swallowing Difficulty
□ Vomiting
□ Black Tarry Stools

HISTORY OF VACCINATIONS: Please mark the box if you had the following vaccinations:

□ Hepatitis B	□ Pneumovax	□ Shingrix	□ Flu Shot	□ COVID

ADLD
ALASKA DIGESTIVE & LIVER DISEASE

Ph: (907)-569-1333
Fax: (907)-569-1333
www.alaskagi.cco

ACKNOWLEDGEMENT AND CONSENT

I understand that **Providers: Daryl M. McClendon, MD, Jeffrey W. Molloy, MD, Austin T. Nelson, MD, Martin P. Kaszubowski, MD, and/or Terri L. Tope, ANP** (Referred to below as "The Providers") will use and disclose health information about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information About my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that The Providers' may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various offices, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of The Providers', and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some and/or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and understand that "The Providers" is not required by law to agree to such requests.

Your Right to Privacy

We understand that you may have concerned relatives and we respect your right to privacy regarding medical information. Please list names of individuals with whom we may share information without additional written consent.

Name / Relationship / Contact Number:	
Name / Relationship / Contact Number:	

By signing below, I agree that I have reviewed and understand the above information and that I have received or been offered a copy of the Notice of Privacy Practices.

_____ _____

Patient's Signature Date

Financial Policy

Thank you for choosing Alaska Digestive and Liver Disease, LLC for your healthcare needs. We are committed to providing you with the best possible medical care. Prior to your scheduled appointment, please call your insurance company for your benefit coverage. The following information outlines your financial responsibilities related to payment for professional services.

ALL PATIENTS

Patients are responsible for any charges incurred on the account resulting from treatment provided. Any balance due must be paid 30 days from the date of service, unless you have contacted our billing office (907)-569-1333 to make payment arrangements.

- **Returned Checks**

A $35.00 charge will be added to your account for any check returned by your bank for any reason. This will be in addition to charges made by your bank.

- **No show/ Canceled/ Rescheduled Services**

As a specialty provider our office visits schedule several weeks out, we also perform a large volume of procedures which require considerable time and resources to perform. Please be considerate of your fellow patients and our office staff and allow at least 2 business days' notice for cancellations/rescheduled office visits and 4 business days for procedures. Our office reserves the right to charge patients that do not provide us with the appropriate notification in cancelling/rescheduling the appointment. Our policy is to charge $50.00 for missed office visits and $100 for missed procedures.

- **Collections**

We utilize a collection agency for past due/unpaid accounts over 90 days from the date of service or last payment received. If there are any issues with your account, please contact our office with questions and/or concerns. If there was an insurance issue that was not discussed or resolved prior to your account going to collections, you are responsible for the bill.

INSURED PATIENTS

As a courtesy, our office will bill your primary and secondary insurance for you. We cannot bill your insurance company unless you give us your correct insurance information. Please understand that your medical insurance is a contract between you and your insurance company. We are not party to that contract. Patients are responsible for knowing their coverage limitations and benefits. The billing office cannot guarantee payment for services or quote benefits from your health plan.

- **Referrals and Pre-Authorizations**

Our billing office will attempt to obtain a referral or pre-authorization if your plan requires one. If you choose to be seen prior to receiving the referral or authorization, your insurance may not pay for your appointment.

- **Procedures**

If you receive services at Alaska Digestive Center you will receive a separate bill with a charge for the facility and a separate bill for the physician's time. You may also receive separate bills for anesthesia and any laboratory or pathology services. If your procedure is performed in the hospital you will receive separate bills from the hospital.

- **Helpful Information**

You are responsible for your bill whether your insurance pays or not. To assist you in finding benefit coverage for your plan, call your insurance company with the following information: Provider Name, Provider tax ID if available, and Procedure(s) to be performed.

UNINSURED PATIENTS

Patients without insurance will be required to make a deposit at the time of service. New patients are required to bring $250; established patients $175, and colonoscopy procedures are $1029, and Upper Endoscopy $716. If there is a balance remaining you will receive a statement.

AUTHORIZATION

- I authorize providers Daryl M. McClendon, MD, Jeffrey W. Molloy, MD, Austin T. Nelson, MD, Martin P. Kaszubowski, MD, and/or Terri L. Tope, ANP to submit claims for benefits without obtaining my signature on each and every claim.
- I authorize my insurance(s) benefits to be paid to providers Daryl M. McClendon, MD, Jeffrey W. Molloy, MD, Austin T. Nelson, MD, Martin P. Kaszubowski, MD, and/or Terri L. Tope, ANP. 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.
- I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

Responsible signature:_____ Date: _____

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)

ADLD
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:

___________ ___________ ___________ ___________ ___________ ___________

___________ ___________ ___________ ___________ ___________ ___________

ALASKA DIGESTIVE AND LIVER DISEASE
3851 Piper Street Suite U-466. Anchorage, AK 99508
Phone: 907-569-1333 Fax: 907-569-1433

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT

Name:_____ **Birth Date:**____/____/____

Other Names Used:_____

FROM

☐ **I request patient's information be sent by**:
☐ Dr. Daryl M. McClendon
☐ Dr. Jeffrey W. Molloy
☐ Dr. Austin T. Nelson
☐ Dr. Martin P. Kaszubowski
☐ Terri L. Tope, ANP
☐ Another health care provider name here**:**_____

PROVIDE TO

Who do you want the patient information to be sent to?

Name:_____ **Phone Number:**_____

How do you want the medical information to be sent?

☐ It will be picked up.
☐ Fax to**:**

☐ Mail to this address: _____

☐ Other (describe)**:**_____

*****Sending information by Fax increases privacy risks, as they involve increased risk of accidental disclosure. Information sent electronically may also be vulnerable to cyber-attack.

REQUESTED INFORMATION

Please check or describe the health information that you would like disclosed:

☐ Complete Record	☐ Discharge Summaries	☐ History & Physical Exams
☐ Consultations	☐ Physician Reports	☐ Radiology & Imaging Reports
☐ Medications Records	☐ Pathology Reports	☐ Laboratory Results

☐ Records for the following dates or treatment**:**_____
☐ Other**:**_____

Specific Sensitive Information needs to be initialed to be disclosed:
___Mental/Behavioral Health Treatment___Drug/Alcohol Abuse___HIV/AIDS Information___STD Treatment

PURPOSE

Why are you requesting this disclosure?
☐ Personal Use ☐ Legal ☐ Insurance ☐ Continuation of Care ☐ Second Opinion ☐ Other**:**_____

VALIDITY

Expiration: This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here:___/___/___ **Revocation:** An authorization may be revoked at any time by written notice to Alaska Digestive and Liver Disease Management. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.

PATIENT RIGHTS

I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse to sign this authorization - ADLD may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or copy my health information. I may arrange to inspect or copy information maintained by ADLD by contacting Health Information Management. I may be charged a reasonable fee for copying costs.

REQUESTOR

I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original.

Signature:_____ **Date:**____/____/____

Print Name:_____

Relationship to Patient: ☐ Self ☐ Parent/Guardian ☐ Legally Authorized Representative ☐ Other: _____

OFFICE USE ONLY: Verification Method:_____ ☐ Priority or ☐ Archive
Sent by: ☐ PU ☐ Mail ☐ Fax ☐ Email ☐ Other:_____ Date Sent:____/____/____ Staff Initials:_____