



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 May Leave a Message <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like to receive automated appointment reminders?		Preferred 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	
<div style="background-color: yellow; border: 1px solid black; padding: 5px; margin-bottom: 10px;"> ❖ The information I have provided above is true, accurate, and complete. </div> ❖ 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. Attach additional pages if needed.

Medication Name	Dosage	Frequency			
		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
		1x/day	2x/day	3x/day	as needed

Are you on any blood thinners (e.g. Coumadin, Plavix, Xarelto, Eliquis, etc....) YES NO

ALLERGIES

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

None X-ray/Radiology Contrast Other *Please specify:* _____
 Latex Antibiotics *Please specify:* _____

PAST MEDICAL HISTORY

Have you EVER experience any of the following? If the answer is, "Yes," please select the box.

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

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	
	<i>Please specify:</i> _____	



Patient Medical History

Name _____

Date of Birth _____

PAST ENDOSCOPIC HISTORY

Type of Endoscopic Procedure	Date	Did they find Polyps?	
		YES	NO
		YES	NO
		YES	NO
		YES	NO

Have you ever had a problem with sedation or anesthesia? YES NO
 If yes, please describe: _____

SOCIAL HISTORY Please select all that apply.

Tobacco Use **Alcohol Use** YES NO
 Never How many drinks per week _____
 Current Smoker
 Former Smoker **Recreational Drug Use** YES NO
 Chew Current Use: _____
 Vape Which Form: _____

FAMILY HISTORY

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

Disease	Relationship			
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"

Fatigue Heartburn Passing Blood with Stool Vomiting
 Abdominal Pain Belching Weight Loss Nausea
 Abdominal Bloating Regurgitation Swallowing Difficulty Chest Pain
 Constipation Diarrhea Black Tarry Stools

VACCINATION HISTORY: Please mark the box if you have that the following vaccinations:

Hepatitis B Pneumovax Shingrix Flu Shot COVID

 Patient Signature

CONSENT FOR TREATMENT

- I authorize Daryl M. McClendon, M.D., Jeffrey W. Molloy, M.D., Austin T. Nelson, M.D, Martin P. Kaszubowski, M.D., Terri L. Tope, ANP, and/or Erica J. Heagy, ANP to administer medical treatment and access my electronic prescription records for continued care and further treatment and,
- I hereby authorize the following facilities:
 - Providence Medical Center,
 - Alaska Regional Hospital,
 - Surgery Center of Wasilla, and/or
 - Alaska Digestive Center are hereby

to review/access my Alaska Digestive & Liver Disease medical record for treatment and diagnostic record for coordination of care.

Patient Signature

Patient Name

Today's Date

PRIVACY POLICIES ACKNOWLEDGEMENT & CONSENT

I understand that **Providers: Daryl M. McClendon, MD, Jeffrey W. Molloy, MD, Austin T. Nelson, MD, Martin P. Kaszubowski, MD, Terri L. Tope, ANP and/or Erica J. Heagy, 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.

We participate with **healtheConnect** the Alaska health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about **healtheConnect** medical record sharing policies. You may visit their website at <https://healtheconnectak.org/>.

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, 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	Phone Number
Name	Relationship	Phone 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 Signature	Patient Name	Today's Date
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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, and 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, Terri L. Tope, ANP, and/or Erica J. Heagy, 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 all provisions of this Patient Financial Responsibility Form.

Patient Signature

Patient Name

Today's Date



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

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	<input type="checkbox"/> I request patient's information be sent by: <input type="checkbox"/> Dr. Daryl M. McClendon <input type="checkbox"/> Terri L. Tope, ANP <input type="checkbox"/> Dr. Jeffrey W. Molloy <input type="checkbox"/> Erica J. Heagy, ANP <input type="checkbox"/> Dr. Austin T. Nelson <input type="checkbox"/> Dr. Martin P. Kaszubowski <input type="checkbox"/> 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? <input type="checkbox"/> It will be picked up. <input type="checkbox"/> Fax to: _____ <input type="checkbox"/> Mail to this address: _____ <input type="checkbox"/> Other (describe): _____ <small>*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.</small>
REQUESTED INFORMATION	Please check or describe the health information that you would like disclosed: <input type="checkbox"/> Complete Record <input type="checkbox"/> Discharge Summaries <input type="checkbox"/> History & Physical Exams <input type="checkbox"/> Consultations <input type="checkbox"/> Physician Reports <input type="checkbox"/> Radiology & Imaging Reports <input type="checkbox"/> Medications Records <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Records for the following dates or treatment: _____ <input type="checkbox"/> 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? <input type="checkbox"/> Personal Use <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Continuation of Care <input type="checkbox"/> Second Opinion <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Legally Authorized Representative <input type="checkbox"/> Other: _____

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