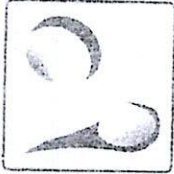

Kern Gastroenterology Medical Group

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Robin A. Matuk, M.D. • Ishaan S. Kalha, M.D.• Neil S. Bhogal, M.D.
Diplomates American Board of Gastroenterology

Welcome to our Practice

Thank you for choosing Kern Gastroenterology Medical Group as your gastroenterology Provider.

What to expect: Being well prepared for your appointment will ensure that the doctor has all the needed information to provide you the best possible care for you. Before your visit, gather your family history information and make a list of all your medications to include the dosage for each. Bring your health insurance card(s), picture ID covid card if you have one. Due to limited space in our reception area, we ask that only one person to accompany the patient. No children please.

Office Policies:

Appointments:
Our schedule is very full and missed appointments mean that someone else who needed to get in to see the doctor, will not have that opportunity. If you are running late for an appointment, please call. If you are more than 15 minutes late your appointment will be rescheduled.

Missed or cancelled appointments please be aware there is a $75.00 penalty which will be charged for missed appointments which must be paid before the next appointment can be scheduled.
The definition of "no show" is missing a scheduled appointment. The definition of "late cancellation" is failing to call in advance without providing a 24hr business day notification (weekends do not count).

Payments: Full payment and co-payments are due at the time of service. We accept cash, check & credit card.

Payment for procedure(s): If you are scheduled to have a procedure(s), Truxtun Surgery Center, or the hospitals billing office can provide you with the best estimate of charges. Our billing office will call your insurance company to obtain authorization for your procedure(s).
Pre-Authorization is not a guarantee of payment. If you cannot pay your portion in full, the account representative can discuss payment options and/or assist you with a payment plan.

Insurance: As a courtesy to our patients, we will bill your primary and secondary insurance carriers. We do not guarantee that your insurance will cover our services. It is your responsibility to keep our office updated with your most current insurance information.

Refills: Please call your pharmacy at least 5 days prior to running out of your medicine. The office requires this turn-a-round time for prescription refill.

I have read and understand the terms of the office policies. I agree to comply with the terms set forth in this policy for services rendered by Kern Gastroenterology Medical Group.

__________________________________ ____________________
Patient name Date

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Name ______________________________________ ________________________

DOB: ________________ Age: _______ _______ Male _______ Female

Address:_________________________________City:_____________State:_____Zip:___

Home phone# : ____________________ Cellular#: ________________

Employer: __________________________________ Occupation: ____________________

Address: ____Phone: ______________

Spouse name: ___________________________DOB: _______SS#:__________________

Spouse employer: ______________________________ Work phone: _______________

Primary Insurance: ______________________Name of insurance: ____ _______ _______

Secondary Insurance:_____________________ Name of insured: ____________________

Chief Complaint

____

____

Duration: ______________________________________ Date of onset: ____________

Describe your problem: ____

____

____

Test results: Labs, imaging, pathology, or procedure results will be discussed at your follow up appointment. The doctor may call you with any critical or abnormal results, otherwise no results will be discussed over the phone.

Patient Signature: ______________________________________ Date: ____________

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DO YOU HAVE ANY OF THE FOLLOWING:

		Please	circle one
1	Appetite Good?	YES	NO
2	Weight Loss	YES	NO
3	Fever	YES	NO
4	Pain in the Abdomen	YES	NO
5	Difficulty when swallowing food	YES	NO
6	Pain when swallowing food	YES	NO
7	Chest Pain	YES	NO
8	Heartburn	YES	NO
9	Indigestion	YES	NO
10	Nausea	YES	NO
11	Vomiting	YES	NO
12	Problem with greasy or fatty foods	YES	NO
13	Problem with spicy foods	YES	NO
14	Have you noticed any change in your bowel movements	YES	NO
15	Diarrhea	YES	NO
16	Constipation	YES	NO
17	Diarrhea alternating with constipation	YES	NO
18	Blood in stool	YES	NO
19	Blood on toilet paper	YES	NO
20	Mucus in the stool	YES	NO
21	Vomiting of blood or color of coffee grounds	YES	NO
22	Undigested food in the stool	YES	NO
23	Problems with Hemorrhoids or fissures	YES	NO
24	Black or tarry stools	YES	NO
25	Polyps in Colon or Rectum	YES	NO
26	Family history of Colon Cancer	YES	NO
27	Cramping when you move your bowels	YES	NO
28	Are you under undue stress	YES	NO
29	Belching	YES	NO
30	Regurgitation (sour fluid back into throat)	YES	NO
31	Coughing while you sleep	YES	NO

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32	Choking on your food --	YES	NO
33	Asthma or wheezing -- -	YES	NO
34	Canker sores in the mouth ---	YES	NO
35	Sore tongue --	YES	NO
36	Bleeding from the gums ---	YES	NO
37	Hissing noise in your ears ---	YES	NO
38	Do you take Rolaids or Tums or any other over the-counter medication for indigestion	YES	NO
39	Know if you have an ulcer ---	YES	NO
40	Know if you have a Hernia --	YES	NO
41	Feel full after taking a small meal ------------------------------------	YES	NO
42	Bloating --	YES	NO
43	Gas --	YES	NO
44	Noises in your Stomach --	YES	NO
45	Bulky heavy stools which are foul smelling ---------------------------	YES	NO
46	Gallstones ---	YES	NO
47	Gallbladder surgery --	YES	NO
48	Hepatitis or Liver problems --	YES	NO
49	Dark color Urine ---	YES	NO
50	Light color stool --	YES	NO
51	Increase in the size of your abdomen ----------------------------------	YES	NO
52	Food does not taste good --	YES	NO
53	Mid Back pain ---	YES	NO
54	Poor control of bowel movements --------------------------------------	YES	NO
55	Pain the Anus while moving your bowels ------------------------	YES	NO
56	Have you been checked for Colon Cancer? If **"Yes" when:** ____________________	YES	NO
57	Lymph Nodes enlarged ---	YES	NO
58	Have you been in good health most of your life ---------------------	YES	NO
59	Any passing out episodes --	YES	NO
60	Do you feel tired --	YES	NO
61	Any dizziness --	YES	NO
62	Do you have any bleeding problems -----------------------------------	YES	NO
63	Phlebitis (swelling) --	YES	NO
64	Heart Disease ---	YES	NO
65	Have you traveled outside the Country If **"YES"** when: ____________________	YES	NO

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66	Do you smoke --	YES	NO
67	Do you drink alcohol ---	YES	NO
68	Do you drink Milk ---	YES	NO
69	Do you drink Coffee ---	YES	NO
70	Do you take aspirin ---	YES	NO
71	Do you take Arthritis medicine ---------------------------------------	YES	NO
72	Do you take Laxatives --	YES	NO
73	Have you ever abused IV Drugs --	YES	NO

PAST HEALTH HISTORY

List of Illnesses:

1: ______________________ 2: ______________________
3: ______________________ 4: ______________________
5: ______________________ 6: ______________________
7: ______________________ 8: ______________________

HOSPITALIZATIONS: (How many and where)

____

____

OPERATIONS (LIST TYPE):

____

____

____

ALLERGIES: (Food or medicine)

____

____

LIST MEDICATIONS YOU ARE TAKING:

1: ______________ 2: ______________ 3: ______________
4: ______________ 5: ______________ 6: ______________
7: ______________ 8: ______________ 9: ______________

Any Blood transfusions -- YES NO

Have any Blood relatives had any of the following?

Cancer --	YES	NO
T.B --	YES	NO
DIABETES ---	YES	NO
HEART TROUBLE ---	YES	NO
HIGH BLOOD PRESSURE ---	YES	NO
STROKE --	YES	NO
POLYPS ---	YES	NO
ULCERS ---	YES	NO
BLEEDING TENDENCY ---	YES	NO
ARTHRITIS --	YES	NO
ANEMIA --	YES	NO
COLITIS --	YES	NO

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LIVER PROBLEMS --	YES	NO

ANY DECEASED IN THE FAMILY (Please include parents, siblings) List cause of death

1: ____

2: ____

3: ____

4: ____

5: ____

Are You: (Please circle one)

Married	YES	NO
Single	YES	NO
Separated	YES	NO
Divorced	YES	NO
Widowed	YES	NO
	YES	NO

Anything else you would like to tell us

____

____

____

____

____

____

____

Physician: ____

Date: ____

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ASSIGNMENT OF BENEFITS

Patient name: ________________________________ DOB: ________________________

I hereby authorize Kern Gastroenterology Medical Group to furnish information concerning my medical condition and do hereby assign to them all payments for medical services rendered. A copy of this authorization is as valid as the original.
I request that payment of authorized Medicare benefits be made either to me or Kern Gastroenterology Medical Group for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.
I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and uncovered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Authorization for Use and/or Disclose of Protected Health Information

(Release of Medical Records)

If my Healthcare information is needed, I Authorize Kern Gastroenterology Medical Group to obtain information from:

Insurance Co. / Third party review: ____

Address: ____

City: ______________________ State: __________ Zip: ____________ Phone: ______________

Purpose of request for information: Medical history, Health Insurance, Laboratory, X-Rays, MRI & CT scans.

Automatic one-year renewal: This authorization will automatically renew each year from the date signed.

Patient signature: ____________________________________ Date: ______________

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Acknowledgement and Patient Preferences
Designee to Receive information

Patient name: ______________________________ DOB: ______________

HIPPA (The Health Insurance Portability and Accountability Act) provides protection to patients intended to limit disclosure of protected health information (PHI). PHI is any data concerning your treatment in the office. We make every effort to comply completely with these HIPPA privacy regulations. At the same time, we do not want our patients to be inconvenienced when they wish to have a spouse of family member call us for healthcare information pertaining to you from our office when it is inconvenient for you to do so.

Please list designee recipients who can obtain this information:

______________________________ ______________________
Name of Designee to Receive Protected Health Information | Relationship to patient

______________________________ ______________________
Name of Designee to Receive Protected Health Information | Relationship to patient

______________________________ ______________________
Name of Designee to Receive Protected Health Information | Relationship to patient

______________________________ ______________________
Name of Designee to Receive Protected Health Information | Relationship to patient

______________________________ ______________________
Patient signature | Date

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A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing than any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates, and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement, you are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third neutral arbitrator. These three arbitrators hear the case. This agreement helps to limit the legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings. Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.
Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services.

____
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:
Patient's or Patient's Representative's Signature Date:

By: ______________________________ __________
Physician's Authorized Representative's Signature Date:

By: ______________________________
Print Patient's Name

____
(If representative, print Name and Relationship to Patient)