Kern Gastroenterology Medical Group

Rabi S. Bhogal, M.D. • Harpal S. Bhaika, M.D. • Tabassum A. Chowdhury, M.D.
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

5959 Truxtun Ave, Ste 200, Bakersfield, CA 93309• (661) 324-1203 • Fax: (661)324-3195

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Name ______________________________ SS# : ______________

DOB:____________ Age:________ ________ Male ______ Female

Address:______________________City:____________ State:_____ Zip:________

Home phone# : ______________ Cellular#: ______________

Primary Care Physician:______________________________

Referring Physician: ______________________________.

Email:____

Chief Complaint:

____

____

____

______________________. Duration: Date of onset: ______________

PAST MEDICAL HISTORY:

HEART DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
HEART MURMUR	YES	NO
ARTIFICIAL HEART VALVE	YES	NO
LUNG PROBLEMS	YES	NO
ASTHMA	YES	NO
BLEEDING PROBLEMS	YES	NO
JAUNDICE/ HEPATITIS	YES	NO
GALLBLADDER/ STONES	YES	NO
ULCER	YES	NO
COLON CANCER/ POLYPS	YES	NO
PRIOR COLONSCOPY	YES	NO
PRIOR ENDOSCOPY	YES	NO
DIABETES	YES	NO
TB (TUBERCULOSIS)	YES	NO

MEDICATION LIST:

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PAST OPERATIONS (surgeries)

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FAMILY HISTORY	**YES**	**NO**
Colon cancer	______	______
Other cancer	______	______
Diabetes	______	______
Heart Disease	______	______
High blood pressure	______	______
Stroke	______	______
Polyps	______	______
Ulcers	______	______
Bleeding tendency	______	______
Anemia	______	______
Colitis	______	______
Liver problems	______	______

Are you allergic to any medicines? ***If so, please list below***

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Are you on any of the following Medicines? **(** ***Please circle Yes or No*** **)**

Antacids Yes No
Blood thinner (e.g. Coumadin) Yes No

Aspirin or Arthritis Meds. Yes No
Laxatives Yes No

Social History:

Do you smoke Yes No
Have you used illegal IV drugs Yes No

Do you drink alcohol Yes No

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History & Physical Review of System: ***(Please circle yes or no)***

Poor appetite	Yes	No	Abdominal Cramps	Yes	No
Weight loss	Yes	No	Bloating	Yes	No
Fever	Yes	No	Difficulty swallowing	Yes	No
Chills	Yes	No	Choking on food	Yes	No
Diarrhea	Yes	No	Shortness of Breath	Yes	No
Constipation	Yes	No	Chest Pain	Yes	No
Alternating Constipation/Diarrhea	Yes	No	Pain on swallowing	Yes	No
Blood in stool	Yes	No	Cough at night	Yes	No
Mucus in stool	Yes	No	Asthma / Wheezing	Yes	No
Black tarry stool	Yes	No	Sores in mouth	Yes	No
Easily filled up after meals	Yes	No	Gums bleeding	Yes	No
Heartburn	Yes	No	Dizziness	Yes	No
Nausea	Yes	No	Joint Pains / Swelling	Yes	No
Vomiting	Yes	No	Belching or regurgitation	Yes	No
Vomiting blood or coffee grounds	Yes	No			

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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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Policy: No Recording Devices Allowed in Medical Practice Premises

Purpose:
The purpose of this policy is to uphold the utmost standards of confidentiality, privacy, and professionalism within the medical practice by strictly prohibiting the use of recording devices on the premises.

Scope:
This policy applies to all patients, visitors, and personnel within the medical practice premises.

Policy Statement:
1. The use of recording devices, including but not limited to smartphones, cameras, audio recorders, and video recorders, is strictly prohibited within the medical practice premises.
2. Patients, visitors, and personnel are prohibited from utilizing recording devices for any purpose while inside the medical practice, encompassing consultations, examinations, waiting areas, and all communal spaces.
3. This prohibition extends to the recording of conversations, medical procedures, examinations, or any other activities transpiring within the medical practice.
4. Any individual found contravening this policy will be promptly instructed to cease recording and may face disciplinary measures, including expulsion from the premises and potential legal repercussions.
5. Exceptions to this policy may only be granted with explicit, prior written consent from both the healthcare provider and all parties involved in the recording.

Implementation:
1. Prominent signage indicating the prohibition of recording devices will be conspicuously displayed throughout the medical practice premises.
2. Personnel will receive comprehensive training to enforce this policy and manage any infractions in a courteous and efficient manner.
3. Patients and visitors will be apprised of this policy through various communication channels, including signage, verbal instructions, and written documentation.

Compliance:
All patients, visitors, and personnel are expected to adhere to this policy without exception. Noncompliance may result in the consequences delineated above.

Review and Revision:
This policy will undergo periodic review to ensure its continued efficacy and may be revised as necessary to accommodate advancements in technology or regulatory requirements.

Approval:
This policy has been reviewed and endorsed by physicians for Kern Gastroenterology Medical Group 03-01-2024

Patient sign:______________________________________ 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)