Ananthram Reddy, MD **Joseph Reddy, MD**

PATIENT REGISTRATION

9456 Cuaymaca Street Suite 102, Santee CA 92071 Phone: (619) 588-4074 Fax: (619) 588-4004
6699 Alvarado Road Suite 2301, San Diego CA 92120

PATIENT INFORMATION

PATIENT (Legal) Name (LAST) (FIRST) (MI)	BIRTHDATE
ADDRESS (STREET) (CITY) (STATE) (ZIP)	

HOME PHONE NO.	CELL PHONE NO.	EMAIL ADDRESS:
	Can detailed confidential messages be left at this number? □ Yes □ No	Can detailed confidential messages be left at this email? □ Yes □ No
□ MALE		
□ FEMALE		ETHNICITY:
		RACE:
		RELIGION:

PHARMACY	PHARMACY ADDRESS	PRIMARY CARE PHYSICIAN

PREFERRED LANGUAGE:

Do you need an interpreter? □ Yes □ No (this will need to be requested by you through your insurance)

INSURANCE INFORMATION

INSURANCE COMPANY NAME	SUBSCRIBER NAME under **PRIMARY** INSURANCE

	SUBSCRIBER Date of Birth	GROUP NO.	SUBSCRIBER NO./CERTIFICATE NO.

SECONDARY INSURANCE COVERAGE	SUBSCRIBER NAME

	DATE OF BIRTH	GROUP NO.	SUBSCRIBER NO./CERTIFICATE NO.

If Tricare Insurance; Subscriber SSN		

IN CASE OF EMERGENCY

NAME:	RELATIONSHIP:	CELL:

Do you authorize Protected Health Information (PHI) to be discussed with this individual? □ yes □ no

Is there anyone else you would like to authorize PHI to be discussed with?

Name:	Name:
Name:	Name:

I have entered all information to the best of my knowledge and verify that the information listed is accurate and true. I have reviewed and agree to all Dr Reddy's office, Sumana & Ananthram Reddy, MD Inc or Advanced Endoscopy Consultant's Inc to discuss my past, present and future medication and medical information as well as all other PHI with the individuals listed above. I understand that it is my responsibility to contact the office directly to remove an individual listed above and agree that all future additions must be made in writing and signed by me or an authorized representative.

PAYMENT OF BENEFITS: I hereby authorize the filing of my insurance claim(s) and payment of insurance benefits to be made to Dr Reddy's office Sumana & Ananthram Reddy, MD Inc or Advanced Endoscopy Consultant's Inc for services provided to me or members of my immediate family. I give permission Dr Reddy's office Sumana & Ananthram Reddy, MD Inc or Advanced Endoscopy Consultant's Inc to verify any information above. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or any charges not covered by insurance. I am the guarantor. In the event of default, I agree to pay all of the costs of collection, and reasonable attorney's fees. I have read all the information on this sheet and have completed the above. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the information above, failure to do so could result in my insurance payer denying any claims.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY		DATE

Medical History Questionnaire

Today's Date _____

Name: _____ DOB: _____

REASON FOR VISIT

- What GI symptoms are you experiencing? (Check all that apply)
  ☐ Abdominal pain ☐ Nausea / Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn / Acid reflux
  ☐ Bloating / Gas ☐ Blood in stool ☐ Unexplained weight loss ☐ Difficulty swallowing
  ☐ Jaundice (yellowing of skin or eyes) ☐ Change in bowel habits
  ☐ Other: _____
- Duration of symptoms: _____
- Have symptoms worsened over time? ☐ Yes ☐ No

III. Please indicate if you have any current problems, signs or symptoms in any of the following areas: (check all that apply)

☐ Allergies
☐ Blood/Lymph
☐ Eyes
☐ Ears, Nose, Throat
☐ Heart/Circulation
☐ Lungs/Breathing
☐ Muscles/Joints/Bones
☐ Neurological
☐Psychiatric/Depression/Anxiety
☐ Reproductive/Urinary
☐ Skin
☐ Stomach, Digestion/Colon Bowel Habits
☐ Thyroid/Endocrine
☐ Other_____

IV. SOCIAL HISTORY

- Do you smoke? ☐ Yes ☐ No → If yes, how much: _____
- Do you drink alcohol? ☐ Yes ☐ No → If yes, how often: _____
- Have you ever used recreational drugs? ☐ Yes ☐ No

V. FAMILY HISTORY

Does anyone in your family have a history of:
☐ Colon cancer
☐ Crohn's disease / Ulcerative colitis
☐ Celiac disease
☐ Gallbladder or liver disease
☐ Polyps
☐ Other GI conditions:
_____
Relationship(s): _____

VI. MEDICATIONS

List all current medications, including over-the-counter drugs and supplements:

Do you take any of the following regularly?
☐ NSAIDs (e.g., Advil, Motrin)
☐ Aspirin
☐ Antacids
☐ Laxatives
☐ Iron supplements

Date of Last Flu Shot? _____

Have you ever had a Pneumonia Vaccine? _____

Medical History Questionnaire

Today's Date _____

Name: _____ DOB: _____

Do you have:	Check Yes OR No	Explain if YES
Anxiety		
Blood in urine		
Blurred Vision		
Brusing easily		
Burning during urination		
Chest pain		
Chronic Cough		
Deafness		
Depression (past or present)		
Discharge from ears		
Double Vision		
Headaches		
Joint Pain		
Loss of appetite		
Loss of Urine (Incontinence)		
Paralysis		
Palpitations		
Seizures		
Shortness of Breath		
Swollen Joints		
Weight Loss		
OTHER:		

Women only:

When was your last Mammogram? _____

Have you ever had a Bone Density/Osteoporosis Screening? _____

Ananthram Reddy, MD **Joseph Reddy, MD**

- WELCOME TO OUR OFFICE!! We pride ourselves on providing the best care possible for all our patients. The following are office policies and other guidelines that will help you understand the office setting as well as help maximize your insurance benefits. If you have any questions regarding your insurance plan, *you must call* the number on your insurance card. There are thousands of different plans, therefore our office no longer has the ability to give specific information. Any information provided is strictly speculated, we do not guarantee that our physicians are participating providers for your specific plan and the physicians do not give advice regarding your insurance plan. Any information given should not be considered fact or a guarantee of payment.

-- PLEASE READ CAREFULLY -- Patient Responsibilities

- **PATIENTS ARE RESPONSIBLE FOR KNOWING THE REGULATIONS AND COVERAGE POLICIES OF THEIR INSURANCE PLAN**.
- All ***patients are responsible for verifying that the doctor you are seeing is a participating provider for your specific plan (especially Anthem Blue Cross members)***. Our doctors do not belong to all plans. Failure for the patient to verify this could result in their insurance plan denying claims. Our office cannot do this for you.
- The patient must notify our office if their insurance plan has any specific requirements. That would include but is not limited to the need to obtain authorization, the need to use a specific laboratory, radiological facility or treatment facility. Screening benefits are not included in every insurance policy. The patient needs to verify this with their insurance plan.
- To avoid "balance billing", the patient is responsible for knowing if a particular physician, consulting physician, referring physician, inpatient/outpatient facility, laboratory, anesthesiologist, radiology facility or any other treatment facility is contracted with their specific insurance plan. If they are not contracted with your insurance plan, you may be balanced billed.

- ***IMPORTANT !!*** If you have a PPO/EPO/ POS or Commercial plan (any plan other than an HMO) the patient is *required* to notify our office if your insurance plan requires prior authorization or precertification for procedures. Failure to do so could result in the patient being fully responsible for any unpaid claims.
- It is the ***patient's responsibility*** to understand their own individual insurance policy benefits. If the information given is not current at the time of service, the patient will be responsible for the entire payment.
- The patient must notify our office **immediately** if their insurance ***changes at any time*****.** There are specific deadlines for submission of claims. If we do not have the correct insurance information and the claim does not get submitted prior to the deadline, the patient will be responsible for the entire payment of any denials by the insurance company.
- If you have a secondary insurance ***please give us the information*****.** There is a time limit to file these claims. Failure to give our office this information could result in the patient being responsible for any and all balances not paid by the secondary insurance.
- ***COPAYS:*** Copays must be paid at the time of your appointment, including follow-up visits after a procedure.
- ***COINSURANCES & DEDUCTIBLES*** may be required in advance for high deductible and high coinsurance plans before scheduling certain procedures.
- ***Missed Appointments: $50.00 charge for all missed office visit appointments and $100.00 charge for missed/canceled procedures if our office is not notified 5 business days not including holidays, prior to the cancellation.***

If you are ever scheduled for a procedure: (very important)

- You may receive a bill from our ***office***, ***the facility*** and the ***laboratory.***
- Our physicians have a financial interest in Grossmont Surgery Center, however you have the option of using Grossmont Hospital or UCSD East Campus, if your insurance is contracted with these facilities.
- If a "Screening" procedure becomes a therapeutic/diagnostic procedure you may have a higher copay, and a deductible may apply for both the physician and the facility. Please check with your insurance company, as this is the sole responsibility of the patient. If the patient has any lower gastroenterology symptoms it will not be billed as screening.
- If you have previously had colon polyps and you will be undergoing a colonoscopy, please be aware that your insurance plan may not apply this to your screening benefits. It is solely up to the discretion of your insurance plan. The patient will need to call their insurance to clarify (our office does not provide this service).
- If the physician documents on the procedure note that the colonoscopy was screening it cannot be changed to diagnostic and vice versa.

By signing the form below you are acknowledging that you have read and understand the items above and acknowledge that this is a legal binding agreement.

_____ _____ _____

Print Name Sign Date

(updated 03/2024)

Ananthram Reddy, MD & Joseph Reddy, MD

6699 Alvarado Road Suite #2301
San Diego, CA 92129

9456 Cuyamaca Street Suite 102
Santee, CA 92120

Tel: 619-229-1005/619-588-4074 *Fax: 619-588-4004*

Name:_____DOB:_____

Acknowledgement of Receipt of Notice of Privacy Practices Information/HIPAA Compliance Requirement Form

I _____acknowledge that I have received a copy of
(patient name printed)
the "Notice of Privacy Practices" per HIPPA. The Notice is also available on the Clinic website, www.reddygastro.com, under Patient Registration, HIPAA Compliance. This notice describes how Advanced Endoscopy Consultants Inc/Sumana & Ananthram Reddy, MD Inc and staff may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
(signature of patient/representative) (date)

_____
(print name and relationship to patient)