ADOBE GASTROENTEROLOGY, P.C.
2585 N. Wyatt Drive
Tucson, Arizona 85712

Gastroenterology & Hepatology
Diplomates, American Board of Internal Medicine and Gastroenterology

SAM E. MOUSSA, MD **DOUGLAS S. PETERSON, MD** **BASSEL KISSO, MD** **PRABHAKAR P. SWAROOP, MD**

Office Appointments (520) 721-2728 ▪ Billing Questions (520) 449-8940

Fax (520) 721-0179

Thank you for scheduling an appointment at Adobe Gastroenterology.

Your appointment with □ Dr. Moussa □ Dr. Peterson □ Dr. Kisso □ Dr. Swaroop

Is Scheduled for Mon Tue Wed Thurs Fri _____ at _____am/pm
Date Time

PLEASE BRING THE FOLLOWING ITEMS TO YOUR VISIT

1. All attached forms **COMPLETED** to the best of your knowledge
   DO NOT FORGET MEDICATION LIST OR MEDICINES
2. A referral from your PCP if required
3. Your INSURANCE card
4. TEST RESULTS- Ask your PCP for reports he or she feels you might need at your visit. This may include blood tests, stool tests, X-rays, CT or sonogram report
5. If you have a co-payment, it will be due on the day of your appointment. We accept cash, check, debit or credit

Please see other side of this form for directions & map.

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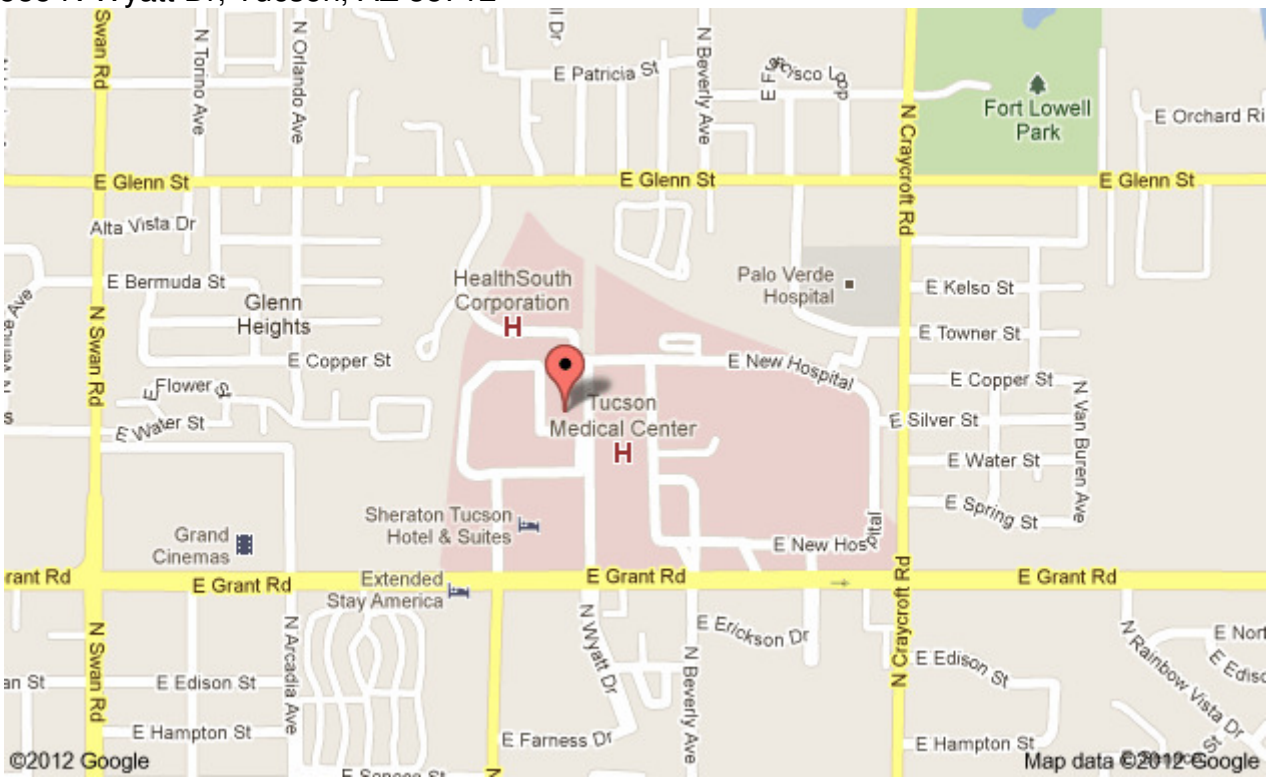
2585 N Wyatt Dr, Tucson, AZ 85712



We are located
2585 N. Wyatt Drive ▪ Tucson, AZ 85712
North Side of Grant Rd (Between Grant Rd & Glenn)
West of Craycroft (Between Beverly & Rosemont)
East of Swan

Turn North on Wyatt Dr from Grant Rd
between Sheraton Hotel & Tucson Orthopedic Institute

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Sam E. Moussa, MD / Douglas S. Peterson, MD / Bassel Kisso, MD / Prabhakar P. Swaroop, MD

Patient Registration

Patient Information

Patient Name(Last)_____(First)_____(Middle)_____

Sex □ Male □ Female □ Trans Gender Date of Birth_____/_____/_____ SS#:_____-_____-_____

Email: _____ Mailing Address_____

Can we contact you by email? □ Yes □ No

Home Address(Street)_____(city/state&/zip)_____

Home Phone(____)_____(Cell Phone)_____(Work)_____

Emergency Contact:_____ Phone #_____ Relationship:_____

Marital Status : □ Married □ Single □ Divorced □ Widow
Ethnicity: □ Hispanic OR Latino □ Non Hispanic □ Refused to Report
Race: □ White □ Black or African American □ American Indian OR Alaska Native □ Native Hawaiian or Other Pacific Islander □ Other Race □ Asian or Other Pacific Islander □ Refused to Report

Employment Status:
Employer:_____ Address:_____ Occupation:_____

Work Status: □ Full time □ Part time □ Unemployed □ Student

Primary Care Physician: _____Phone: _____

Pharmacy Name_____Location:_____Phone:_____

Insurance Information: (Please Provide Your Insurance Card for Us to Scan)

1. Primary insurance Company_____

Policy Holder Name:_____ D.O.B:_____ Relationship: □ Self □ Spouse □ Dependent

Employer of Policy Holder_____ ID#_____ Group #_____

2. Secondary insurance Company_____

Policy Holder Name:_____ D.O.B:_____ Relationship: □ Self □ Spouse □ Dependent

Employer of Policy Holder_____ ID#_____ Group #_____

Signature:_____ Date:_____

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Patient Name _____ **Male** **Female** Date _____
Age _____ Birth Date _____ Referred by _____

➡ What is the primary medical problem for which you seek evaluation, information, or treatments?
_____

PAST HISTORY:
➡ Please indicate if you have or have had any of the following diseases:

Acid Reflux	Diabetes	Hemorrhoids	Hypertension
Ulcers	Heart murmur	Heart Attack	Pacemaker
Stroke	Cancer	Anemia	Tuberculosis
Herpes	Shingles	Mononucleosis	Schizophrenia
Anxiety	Panic attacks	Depression	Suicide attempts
Bipolar disorder	Hepatitis	Obsessive Compulsive Disorder	
Recent 'flu-type' illness	Jaundice		

➡ **List All Other Chronic Medical Conditions**: (e.g. - Hyperlipidemia, heart disease, irregular heart rhythm, blood clots, COPD/emphysema, etc.)

_____ _____
_____ _____
_____ _____

SURGICAL HISTORY:
➡ Have you had any surgery? (Type of operation and approximate date)

_____ _____ _____
_____ _____ _____

➡ In the past 5 years have you had any of the following? Please check the appropriate answer.

1. Stool tested for blood	No	Yes	Date _____
2. Colonoscopy or Flexible sigmoidoscopy	No	Yes	Date _____
3. CAT scan of abdomen	No	Yes	Date _____
4. Barium enema or Barium upper gastrointestinal series	No	Yes	Date _____
5. Liver biopsy	No	Yes	Date _____
6. EGD or Upper Endoscopy	No	Yes	Date _____

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Patient Name: _____ *Date:* _____

Family History: Do you know of any relative who has or had any of the following cancers or diseases?

Cancer History:

Esophageal _____ Liver _____
Stomach _____ Pancreas _____
Colon _____ Other _____

Diseases in the Family

Ulcerative Colitis	Hepatitis B or C	Stroke/ Transient stroke
Crohn's Disease	Epilepsy	Migraine
Colon Polyps	Acid Reflux Ulcers	Lung Disease
Irritable Bowel Syndrome	Liver Disease	Mental Illness
Celiac disease	Heart Disease	Alcohol/Drug Abuse
High Cholesterol	Diabetes	Ulcers
Kidney Disease	Genetic Disorders	Arthritis

Social History

Substance	Current Use	Previous Use	Type / Amount	How long / Frequency	If Stopped, when?
Caffeine (coffee, tea, soda)					
Tobacco					
Alcohol					
Recreational or Street drugs					

PERSONAL HISTORY:

1. Please list your primary language: English Spanish Russian Indian (includes Hindi & Tamil)
   Other:_____

2. Education: How many years of school have you completed?_____

3. Occupation: Current employment status: Employed Homemaker Unemployed Retired
   Current Job: _____Previous occupation/jobs: _____

4. Disability: Are you disabled? No Yes Cause:_____

5. Marital Status: Single Married Separated Divorce Widowed

6. Current Spouse: N/A Alive Health problems or cause of Death _____
   If alive, current employment status: Homemaker Employed Retired Unemployed

   Current Occupation of spouse: _____

7. Number of Children _____ Boys _____ Girls _____

8. Have you ever been Physically, Sexually, or emotionally abused? No Yes

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Name:_____ DOB:_____ Today's Date:_____

ROS

General/Constitutional
□ Fatigue □ Change in appetite □ Chills □ Fever

Ophthalmologic
□ Yellow Eye □ Blurred vision □ Discharge □ Pain

ENT
□ Hoarseness of voice □ Decreased hearing □ Swollen glands □ Sore Throat

Respiratory
□ Cough □ Shortness of breath at rest □ Shortness of breath with exertion □ Wheezing

Cardiovascular
□ Chest pain at rest □ Chest pain at exertion □ Palpitations

Gastrointestinal
□ Flatulence □ Rectal pain □ Vomiting Blood
□ Abdominal Swelling □ Milk Intolerance □Abdominal Pain
□ Blood In Stool □ Constipation □ Diarrhea
□ Difficulty Swallowing □Exposure To Hepatitis □ Heartburn
□ Hematemesis □Nausea □Vomiting
□ Rectal bleeding □ Weight loss
□Change in bowel habits □ Use finger to evacuate Stool

Hematology
□ Anemia □ Easy bruising

Skin
□ Body piercing □ Dry skin □ Rash

Neurologic
□ Stroke □ Headache □ Seizures

Psychiatric
□ Depressed mood □ Substance Abuse □ Suicidal thoughts

Health Education
□Hepatitis vaccination □ Smoking cessation

MEDICATION HISTORY: Current medications :(List all including strength and dose. Include oral contraceptives, over the counter medications, herbal medications, and health supplements)

1._____	5._____	9._____
2._____	6._____	10._____
3._____	7._____	11._____
4._____	8._____	12._____

Have you been prescribed narcotic medications in the past 1-year □ Yes □No

ALLERGIES: □ No □ Yes (if yes list allergies below and type of reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

□Shell fish/seafood allergy □Allergy to dye in CT scan and other imaging studies

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CONSENT FOR TREATMENT:

I consent to treatment by my primary Adobe Gastroenterology physician, _____ MD. I am aware if my primary physician is unavailable, I will be treated by another physician providing coverage for the Adobe Gastroenterology, PC physicians.

_____ _____
Signature of Patient/Responsible Party Date

PAYMENT POLICIES/INSURANCE/INSURANCE RELEASE:

It is my responsibility to pay the doctor for his services. My co-payment is due when services are rendered. For No Show appointments or same day cancellations a charge of $50.00 will be applied. A 24 hour notice is required. I understand this office will file insurance for all Medicare services, all contracted insurance carriers and all surgical services. I authorize release of medical information for my insurance claims or legal purposes and authorize payment of insurance benefits to Adobe Gastroenterology, PC or Adobe Surgery Center, PC. I authorize my physician at Adobe Gastroenterology, PC to obtain my medical records and lab results from other facilities I have visited, as they deem necessary. I understand that I am personally responsible for referrals from my PCP and all charges not covered by insurance. If collection proceedings are required, I agree to pay all collection and legal fees incurred by Adobe Gastroenterology and Adobe Surgery Center.

_____ _____
Signature of Patient/Responsible Party Date

ADOBE GASTROENTEROLOGY, P.C.
ADOBE SURGERY CENTER, P.C.
2585 N. Wyatt Drive
Tucson, Arizona 85712
Phone: (520)721-2728 Fax: (520)721-0179

BECOME FAMILIAR WITH YOUR INSURANCE BENEFITS

Please contact your insurance company to inquire what your benefits may be. Your insurance company without notice may change benefits. For example, upon renewal of many contracts, there are new deductibles, or the amount of an existing deductible has increased. Also, co-insurance and co-payment amount may change at the start of a new benefit year. Please note that it is your responsibility to notify us of any changes in benefits and/or coverage. The quote you receive from our practice is an estimate only and other procedures may be necessary at the date of your appointment that was not included in the estimate. ***It is your responsibility to know your insurance benefits. Please contact your insurance company with benefit questions and all financial responsibilities prior to your procedure and office visit.*** Also, your insurance may require separate patient responsibility for office consults and procedures. Please be advised final patient out of pocket cost is determined by your insurance. In the event that your payment exceeds the final insurance determined amount, you will receive a refund for the over payment.

By following these steps, you will be aware of any cost that may be responsibility after your insurance pays.

When having a procedure, two separate charges will be billed to your insurance: one from Adobe Gastroenterology, PC. for the professional fee and one from Adobe Surgery Center, PC. for the facility charge.

SELF-PAY PATIENTS:

Possible Additional Costs:

- If a second procedure is deemed necessary by the physician after preliminary payment has been made.
- If any pathology is required. (there will be an additional bill from Miraca Diagnostics)

If you should have any further questions or need any additional information after speaking with your insurance, please contact us at 520-721-2728.

Signature_____ **Date**_____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or your protected health information may be provided to a physician to whom you have been referred or seek counsel from, to ensure that physician has the necessary information to diagnose or treat you.

Treatment and office visits in our facility will require that you be called by name in the reception area. You will be asked personal and medical history questions by medical personnel to ensure safe and appropriate care in our surgery center. You may share a pre- or post-op area with other patients in our surgery center.

Obtaining approval or scheduling procedures or a hospital stay may require that your relevant protected health information be disclosed to the health plan or medical facility.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, medical studies, and conducting or arranging for other business activities. You may be greeted by name at our reception desk and ask to complete registration forms or sign consent for procedures. We may also call you by name in the reception area when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or inform you of test results. We may contact you by telephone, E-mail, Postal Service or other forms of delivery services, as your doctor deems necessary.

Research: We may use and disclose medical information about our patients for research purposes, subject to the confidentiality provisions of state and federal law. Occasionally, researchers contact patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form. When approved through a special review process, other studies may be performed using your medical information without requiring your consent. These studies will not affect your treatment or welfare, and your medical information will continue to be protected. For example, a research study may involve a chart review to compare the outcomes of patients who received different types of treatment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity and National Security; Workers' Compensation; Inmates, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

See reverse side

Telephone calls to Adobe Gastroenterology/Surgery Center, P.C., may be monitored or recorded randomly, by management, for quality assurance or training purposes only.

Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or opportunity to object unless required by law.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Your Rights Regarding Your Health Information

You have the right to inspect and copy your protected health information. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must submit your request for medical records in writing to your Doctor.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request, in writing, must state the specific restriction requested and to whom you want the restriction to apply. *(Please ask the receptionist for a form.)*

Your physician is not required to agree to a restriction that you may request, unless you have requested a restriction on information disclosed to a health plan when you have covered the entire cost of service. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You also have the right to request, in writing, to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to ask your physician to amend your protected health information. If you believe your medical record is incorrect or incomplete, you may request to amend your records through the use of an authorized amendment form. The original form must be placed into your medical file at this practice. You may request an amendment form from this office. Your request must be made in writing and submitted to your doctor at Adobe Gastroenterology, 2585 N. Wyatt Drive, Tucson, AZ 85712. The original information will also be retained in your file.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided in this notice.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with us by notifying our HIPAA Compliance Officer. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before July 1, 2013.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. You may ask our office for a copy of this Notice at any time. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (520) 721-2728.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: _____ Printed Name: _____ Date:_____

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OPTIONAL:

I, _____, DOB: _____
(**Print Name**)

Authorize Adobe Gastroenterology, P.C. to give copies of my medical records to Adobe Clinical Research, LLC. I am interested in learning about clinical trials that may be helpful to my medical conditions.

Signature _____Date _____