Advanced Gastroenterology & Hepatology Associates
7102 N. Fresno Street #108 • Fresno, CA 93720
Ph. (559) 297-2259 • Fax (559) 297-2269

FC:_____

PCP:_____

HCL: _____

Patient Information

LAST NAME:_____ FIRST NAME:_____ M.I.: ____

ADDRESS: _____
(Street) (City) (State) (Zip)

DATE OF BIRTH:_____ SEX: ☐ MALE ☐ FEMALE SSN:_____

HOME PHONE: _____ WORK_____ CELL: _____

EMAIL:_____

PATIENT'S EMPLOYER NAME:_____ TELEPHONE:_____

REFERRING DOCTOR:_____ TELEPHONE:_____

I AUTHORIZE ADVANCED GASTROENTEROLOGY & HEPATOLOGY ASSOICATES TO DISCUSS MEDICAL INFORMATION RELATED TO MY CARE WITH THE FOLLOWING FAMILY MEMBERS/INDIVIDUALS.

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP: _____

RESPONSIBLE PARTY INFORMATION

(GUARANTOR)

Primary Insurance:	Secondary Insurance:
Claims Address:	Claims Address:
Insured Name:	Insured Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone: DOB: Sex:	Phone: DOB: Sex:
Insured Employer:	Insured Employer:
Address:	Address:
Phone: Fax:	Phone: Fax:
Patient Relationship to Insured:	Patient Relationship to Insured:

HOW DID YOU HEAR ABOUT OUR OFFICE?: _____

DISCLOSURE: Dr. Jayanta Choudhury, Dr. Muhammad Sheikh and Dr. Mandeep Singh have a financial interest at the Herndon Surgery Center.

INSURANCE CLAUSE: I understand that if this or any other visit precedes the effective date of my insurance; or is not covered by my insurance, I will be held responsible for all fees incurred because of this and any subsequent visit.

FINANCIAL DISCLOSURE: Advanced Gastroenterology & Hepatology Associates is a member of Santé Foundation Medical Group (SFMG) and I may receive a bill from SFMG for services provided by Advanced Gastroenterology and/or the group's providers.

TREATMENT CONSENT: I hereby give consent for medical or surgical treatment to Dr. Jayanta Choudhury, Dr. Muhammad Sheikh and Dr. Mandeep Singh Associates to care for self or I am duly authorized by the patient as his/her general agent to give consent for such treatment.

ASSIGNMENT OF PAYMENT OF BENEFITS: I hereby authorize payment directly to Choudhury, Sheikh & Singh Inc. of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

RELEASE OF INFORMATION: I hereby give consent to release to authorized persons of financial and medical information concerning care and treatment and changes therefore as may be required to complete all claims for benefits.

_____ _____
Patient Signature/ Representitive Signature Date

Advanced Gastroenterology & Hepatology Associates

A member of the Santé Foundation Medical Group
& a part of the Santé Health Foundation

INSURANCE: Advanced Gastroenterology & Hepatology Associates is contracted with most insurance plans. Our staff will make a good faith attempt to determine benefit levels and estimate any charges you may incur. However it is ultimately your responsibility to understand your level of coverage from your insurance company. It is your responsibility to supply us with appropriate billing information, which includes current insurance identification as well as the billing address and anything else required by your insurance carrier for payment of claims. It is your responsibility to be sure that your referral and authorization arrive prior to your visit. Copays are due time of service. If you consent to receive medical services that are considered a "non-covered benefit", you will be held financially responsible for these charges. There may be a $25 administration fee if we need to re-bill an insurance claim because you provided incorrect insurance information. You will be responsible for payment of any co-insurance, co-payment, deductibles, or non-covered benefits, which will be due and payable within 30 days of receiving a statement. If not insured, payment is expected at the time of service. If you are unable to pay the full amount at that time, our billing department will work with you to establish a payment plan. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician and is not a substitute for payment. Please understand that this office can only code and file a claim for your visit(s) with a diagnosis encountered and documented in your medical record. Thus, to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from your insurance carrier is inappropriate.

RETURNED CHECKS: If your check is returned for non sufficient funds, you could be liable for three (3) times the amount of the check or $100.00 whichever is greater, plus the face value of the check and any court costs. Our normal charges for a returned check are the check amount plus $55.00 to cover the bank return fees and administrative processing. Depending on the circumstance you may be required to pay cash for all future services if you have returned checks.

CANCELLATIONS and MISSED APPOINTMENTS
PLEASE INITIAL ON ALL LINES TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE FOLLOWING:

_____ Office visits cancelled or rescheduled less than 24 hours of appointment will be subject to a $75 fee
_____ Office visit NO SHOWs will be subject to a $75 fee
_____ Procedures cancelled or rescheduled less than 7 business days of appointment will be subject to a $250 fee
_____ Procedure NO SHOWS will be subject to a $250 fee

These fees are not billable to your insurance company.

New Disclosure Language Required in 2025

Beginning on July 1, 2025, all health care facilities and providers must include the following term in any contract that creates a medical debt, or the contract is void and unenforceable: A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

NOTE : Advanced Gastroenterology & Hepatology Associates is a part of Santé Foundation Medical Group (SFMG). All billing statements regarding charges incurred for any services provided by our physicians will come from and be processed by SFMG.

I understand the above.

Patient Name: _____ Patient Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I may ask for a copy of this or any amended Notice of Privacy practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

Cancellation Policy

Effective May 1, 2022

As a courtesy to other patients, please notify us if you are unable to keep your appointment.

You may be charged a cancellation fee of $250.00 if you fail to cancel within 7 business days of a procedure, and $75.00 for an office appointment. Your insurance may not cover this fee.

Sign: _____ Date: _____

Race: Asian/A Asian Pacific/F African American/B Caucasian/C
Hispanic/H Alaskan/I Native American/G Other/E

Ethnicity: Latino/Hispanic/L Other/O Not Reported/Refused/N

Language: _____

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Patient Name: _____
DOB: _____
Patient #: _____

Past Medical/Surgical/Social History

Past Medical History. Please check all previous illnesses or conditions below.

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Back problem
- ❑ Barrett's Esophagus
- ❑ Cardiac Disease
- ❑ Celiac disease
- ❑ CHF
- ❑ Cirrhosis
- ❑ Colon polyps
- ❑ COPD
- ❑ Diabetes mellitus
- ❑ Diverticulosis
- ❑ Heartburn
- ❑ Hemophilia or bleeding disorder
- ❑ Hepatitis
- ❑ Hypercholesterolemia
- ❑ Hypertension
- ❑ Hypothyroidism
- ❑ Immune deficiency
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Myocardial infarction
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Prostate disease
- ❑ Sleep apnea
- ❑ Stroke
- ❑ TIA
- ❑ Other: _____

Surgical History. Please check any surgeries you have had and indicate date if known.

- ❑ Appendectomy
- ❑ Bariatric surgery
- ❑ Bladder repair
- ❑ Breast surgery
- ❑ C-Section
- ❑ Colon surgery
- ❑ Colonoscopy
- ❑ Cosmetic surgery
- ❑ Eye surgery
- ❑ Fracture surgery
- ❑ Gallbladder surgery
- ❑ Heart surgery
- ❑ Hernia repair
- ❑ Hysterectomy
- ❑ Joint replacement
- ❑ Ovary removal
- ❑ Pancreas surgery
- ❑ Prostate surgery
- ❑ Small intestine surgery
- ❑ Spine surgery
- ❑ Take Down Colostomy
- ❑ Tonsillectomy
- ❑ Tubal ligation
- ❑ Upper GI endoscopy
- ❑ Valve replacement
- ❑ Vasectomy
- ❑ Other: _____

Social History

Do you smoke? ❑ ❑ No ❑ Yes If yes, how many packs a day? _____
Do you drink alcohol? ❑❑ No ❑ Yes If yes, how much per week? _____
Do you use smokeless tobacco? ❑ No ❑ Yes If yes, how much per week?_____
Have you ever used intravenous drugs? ❑ No ❑ Yes
Do you have tattoos? ❑ No ❑ Yes

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Allergies & Medications

Please list the following:

Allergies to Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Prescriptions:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Over the counter medications/Vitamins:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Preferred Pharmacy: _____

Address/Cross Street: _____