

Susanna Chan, M.D.  
Jerome Cohen, M.D., FACP  
Norman Panitch, M.D., FACP  
Edward Piken, M.D.



Gloria Sze, M.D.  
Tonny M. Lee, M.D.  
Oren Zaidel, M.D.  
Wendy Ard, PA-C

Dear \_\_\_\_\_,

You have an appointment with Dr. \_\_\_\_\_

On \_\_\_\_\_ at \_\_\_\_\_ AM / PM

We ask that you arrive at least 15 minutes early to Suite 260 with the enclosed forms **COMPLETED** and please bring your insurance card(s) and Identification card. **PLEASE DO NOT MAIL YOUR FORMS TO US !!!**

If you have any additional medical information from a referring physician, such as: medical records, lab work, x-rays, etc. please bring them with you.

If your insurance coverage requires prior authorization, **it is imperative that you bring your authorization referral with you to avoid rescheduling.**

We appreciate your cooperation. Should you have any questions, please do not hesitate to call our office at (310) 539-2055.

Please notify office if change is necessary. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

Thank You,

Scheduling Dept.

**SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP**  
**The Endoscopy Center of the South Bay**

Please check which provider you are seeing:

- Susan M. Chan, M.D.
- Jerome Cohen, M.D.
- Tonny M. Lee, M.D.
- Edward Piken, M.D.
- Gloria Sze, M.D.
- Oren Zaidel, M.D.
- Wendy Ard, PA-C

PRACTICE LIMITED TO GASTROENTEROLOGY

23600 Telo Avenue, Suite 260  
Torrance, California 90505  
Telephone # (310) 539-2055  
Southbaygastro.com

Endoscopy Center of the South Bay  
23560 Madison Street, Suite 109  
Torrance, California 90505  
Telephone # (310) 325-6331

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ SSN: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_  
HOW DO YOU PREFER TO BE CONTACTED?  HOME  WORK  CELL OR  OTHER: \_\_\_\_\_  
MARITAL STATUS: \_\_\_\_\_ GENDER: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_  
DO YOU RESIDE IN A SKILLED NURSING FACILITY: \_\_\_\_\_  
FAMILY PHYSICIAN (REFERRING PHYSICIAN): \_\_\_\_\_ PHONE# \_\_\_\_\_  
PHARMACY NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
RACE:  WHITE  ASIAN  BLACK/AFRICAN AMERICAN  NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER  AMERICAN INDIAN-ALASKAN NATIVE  
 OTHER  
ETHNICITY:  HISPANIC OR LATINO  NON-HISPANIC OR LATINO  Preferred Language:  ENGLISH  OTHER: \_\_\_\_\_

**PRIMARY INSURANCE**

COMPANY: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
MEMBER # \_\_\_\_\_ GROUP # \_\_\_\_\_  
NAME OF INSURED: \_\_\_\_\_ INSURED SSN: \_\_\_\_\_  
INSURED DATE OF BIRTH: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

COMPANY: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
MEMBER # \_\_\_\_\_ GROUP # \_\_\_\_\_  
NAME OF INSURED: \_\_\_\_\_ INSURED SSN: \_\_\_\_\_  
INSURED DATE OF BIRTH: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

EMPLOYER: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_  
RELATION TO PATIENT: \_\_\_\_\_

**EMERGENCY NOTIFICATION**

CONTACT: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_

SIGNATURE OF PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

**SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP  
AND**

**The Endoscopy Center of the South Bay - Patient History Form**

[ PATIENT LABEL ]

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Marital Status:**  Married  Divorced  Single  Widowed

Age \_\_\_\_\_ Weight \_\_\_\_\_ lbs Height \_\_\_\_\_ ft \_\_\_\_\_ inches

**Reason for Visit:** Rectal bleeding  Anemia

Family History  Re-Check  Change in Bowel Habits

Abdominal Pain  Other: \_\_\_\_\_

**History:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

- Cancer (type) \_\_\_\_\_
- Polyps (colon/stomach) \_\_\_\_\_
- Ulcers \_\_\_\_\_
- Liver Disease \_\_\_\_\_
- Pancreatitis \_\_\_\_\_

**Family History** If Living If Deceased

	Age	Health	Age	Cause
Father				
Mother				
Brother/Sister				
Other Blood Relatives				
Son/Daughter				

**Do you smoke?**  Yes  No

# packages per day \_\_\_\_\_

# of years smoked \_\_\_\_\_

**Do you use alcohol?**  Yes  No

# drinks per day \_\_\_\_\_

**Illnesses/Surgeries: PLEASE PROVIDE DATES**

(If none, please indicate with N/A)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Have you ever had a Colonoscopy or an Upper Endoscopy before?**  Yes  No **When?** \_\_\_\_\_

**Results:** \_\_\_\_\_

**Medications:** List all Medications, Dosage & Frequency.

(This should include: All Prescription, Herbal and over the counter Medications) If not applicable, please indicate with N/A.

If necessary please use the back of this form or attach a list.

**DRUG NAME** **DOSAGE** **HOW OFTEN**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**Herbals, Vitamins, Supplements & Non - Prescriptive Drugs:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Allergies:** Include Medication, Foods and Latex. Please note reactions. *(If not applicable indicate with N/A)*

No Known Allergies

**LATEX ALLERGY?** YES  No  Reaction; \_\_\_\_\_

**DRUG ALLERGIES** **TYPE of REACTION**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**FOOD ALLERGIES** **TYPE of REACTION**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

[ PATIENT LABEL ]

Patient Name: \_\_\_\_\_

Cardiovascular

- Heart Murmur, Heart Valve Replacement, Chest Pain, Heart Attacks, Heart Stents

- High Blood Pressure, Defibrillator / Pacemaker, AICD/ \*CRMD, High Cholesterol, Heart Surgery, Swelling of Ankles, Cardiomyopathy or Congestive Heart Failure

Constitutional

- Recent weight change, Fever, Fatigue

Endocrine

- Heat or Cold Intolerance, Excessive Thirst or Urination, Diabetes TYPE 1 or TYPE 2, Thyroid Trouble

Eyes/Skin/ENT

- Blurred and double vision, Glaucoma, Rash / Itching, Jaundice, Hearing Loss / Ringing In Ears, Mouth Sores, Nosebleeds

Gastrointestinal

- Poor Appetite, Difficulty in Swallowing, Heartburn and Indigestion, Nausea or Vomiting, Bloating / Belching, Regurgitation, Constipation, Diarrhea, Abdominal Pain, Recent Change In Bowel Habits, Rectal Bleeding, Black, Tarry Stools, Gallbladder Disease, Liver Trouble, Hemorrhoids, Hiatal Hernia

Musculoskeletal

- Joint Pain or Swelling, Back Pain / Muscle Pain

Genitourinary

- Burning w/Urination, Blood in Urine, Kidney Trouble

Hematological

- Bleeding/Bruising Tendency, Anemia, Blood Transfusion

Respiratory

- Chronic Cough, Spitting up Blood, Wheezing, Shortness of breath, Tuberculosis, Do you use Oxygen?, COPD, Obstructive Sleep Apnea, Do you use a CPAP Machine

Infectious Disease

- Hepatitis, Type: \_\_\_\_\_, AIDS, HIV

Do you currently have any condition that has been deemed Infectious / communicable

Psychiatric

- Memory Loss/Confusion, Depression, Panic Attacks/Anxiety Disorder

Neurological

- Dementia, Alzheimer's, Headaches, Seizures, Strokes, Difficulty laying on Left Side, Numbness, Weakness (Left or Right)

Are you Pregnant?

Is there anything else we should know regarding your medical history?

Who is your referring Doctor?: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Who is your Primary Doctor?: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Address: \_\_\_\_\_

Do you have a Cardiologist? No Yes Please provide:

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

C.R.N.A's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**SOUTH BAY GASTROENTEROLOGY  
MEDICAL GROUP  
AND  
The Endoscopy Center of the South Bay**

**OFFICE POLICY FOR  
INSURANCE BILLING**

South Bay Gastroenterology Medical Group & Endoscopy Center of the South Bay have enrolled in numerous managed care insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans having different stipulations regarding what services are covered and how often they may be performed. These plans differ depending on what type of contract your employer has negotiated.

Because we do not have access to each employers guidelines and stipulations; we must rely on you, the patient, to inform us EACH time of services exactly what those guidelines and stipulations are.

Unfortunately, if you do not inform us of special requirements in your insurance contract such as **lab work, screening / preventative care, hospitalization, and/or out-patient procedures** that are non-covered or must go to a specific location, or the need for a referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Please check with your insurance if you have any questions relating to the services we provide. We want you to receive all of the benefits offered to you.

.....

I have read and understand the office policy stated above and agree to accept responsibility as described.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# The Endoscopy Center of the South Bay And South Bay Gastroenterology Medical Group

## Authorization to Leave Message:

I hereby authorize **SBGMG/ECSB** to leave a message regarding pending appointments or tests at the following:  
(please circle)

**Home :** Yes / No Phone Number: \_\_\_\_\_

**Cell Phone :** Yes / No Phone Number: \_\_\_\_\_

**Work :** Yes / No Phone Number: \_\_\_\_\_

**You may contact me via my Email : Yes / No Email Address:** \_\_\_\_\_

**You may leave a message with any of the individuals listed below:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

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**Print Patient Name:** \_\_\_\_\_

**Patient, Parent or Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(Signature)**

# H2.6c NOTICE OF PRIVACY PRACTICES

**Endoscopy Center of the South Bay - South Bay Gastroenterology Medical Group-** This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

## Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

## How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

## Examples of Treatment, Payment, and Health Care Operations

**Treatment:** We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

**Payment:** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

**Health Care Operations:** We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your care and others like it.

## Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

## Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

**Required by Law:** We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

**Research:** We may use or disclose information for approved medical research.

**Public Health Activities:** As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

**Health oversight:** We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

**Judicial and administrative proceedings:** We may disclose information in response to an appropriate subpoena or court order.

**Law enforcement purposes:** Subject to certain restrictions, we may disclose information required by law enforcement officials.

**Deaths:** We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

**Serious threat to health or safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Military and Special Government Functions:** If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

**Workers Compensation:** We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

## Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

**Request Restrictions:** You may request restrictions on certain uses and disclosures of your health information. We are not required to agree on such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.

**Confidential Communications:** You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

**Inspect and Obtain Copies:** In most cases, you

have the right to look at or get a copy of your health information. There may be a small charge for the copies.

**Amend Information:** If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

**Accounting of Disclosures:** You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

## Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

## Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

## Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

## Contact Person

If you have any questions, requests, or complaints, please contact: Center Director and /or Office Manager.

**Effective Date:** (date form implemented)

I, \_\_\_\_\_,  
(print name)

hereby acknowledge receipt of the Notice of Privacy Practices given to me.

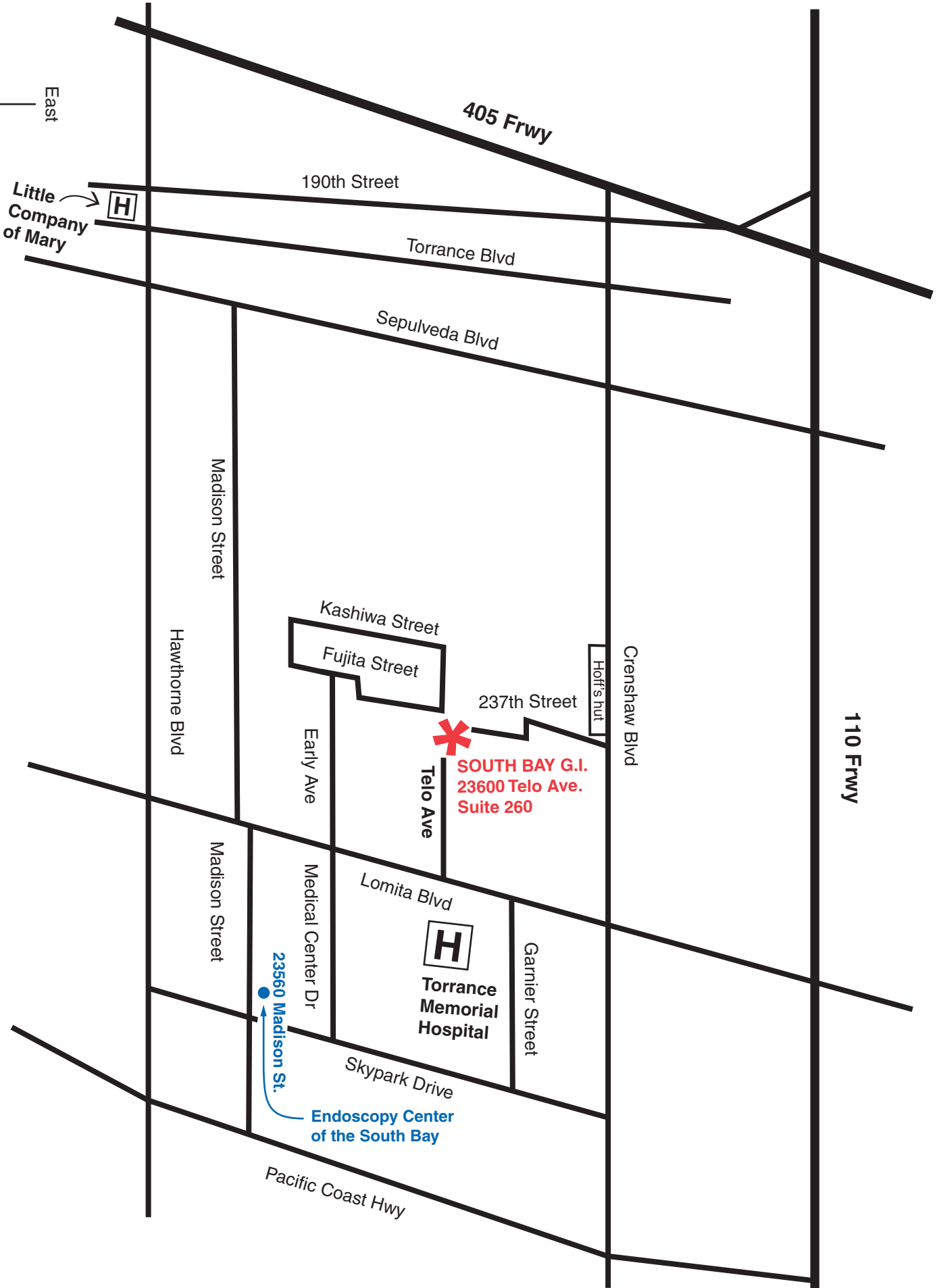
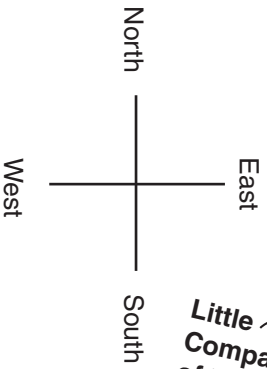
Signed: \_\_\_\_\_

Date: \_\_\_\_\_

If not signed, reason why acknowledgement was not obtained: \_\_\_\_\_

Staff Witness seeking acknowledgement

\_\_\_\_\_ Date: \_\_\_\_\_



South Bay Gastroenterology Medical Group 23600 Telo Ave. #260, Torrance, CA. 90505

**\*** SBGI is located at the South-East corner of Telo Ave and 237th St

• Endoscopy Center of the South Bay