California Colorectal Surgeons

BETH MOORE, MD, FACS, FASCRS
8929 Wilshire Blvd. Suite 302, Beverly Hills, CA 90211 Phone:
(310) 854-3580 • Fax: (310) 659-5830

Welcome to California Colorectal Group. We are glad that you have chosen us to help provide your care and look forward to getting to know you.

Enclosed you will find our new patient information and the documents we need to expedite your visit. Please complete and submit all of the attached documents to our office staff via email or postal mail at **least 3 days prior** to your appointment. If we do not get these in advance, your visit may need be delayed or rescheduled.

When you arrive for your visit, please have all pertinent information required to include your current insurance card and government issued photo ID. All payments are due at the time of service in full. We accept cash, credit cards and checks.

Once again, welcome to California Colorectal Group. Should you have any questions, please do not hesitate to contact us at (310) 854-3580 for assistance.

Warmest Regards,

Dr. Beth Moore, FACS, FASCRS

BETH MOORE, MD, FACS, FASCRS
8929 Wilshire Blvd. Suite 302, Beverly Hills, CA
90211 Phone: (310) 854-3580 Fax (310) 659-5830

PATIENT INFORMATION SHEET

Please Print the information on this form carefully. We need it to prepare our records to take care of government & legal requirements. Thank you for your cooperation.

NAME_____BIRTH DATE_____ AGE_____

SEX: Male Female HEIGHT_____ WEIGHT_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL_____WORK_____

EMAIL_____DL#_____STATE_____

PHARMACY NAME_____PHARMACY PHONE_____

EMPLOYER_____OCCUPATION_____

REFERRED BY _____DOCTOR PHONE_____FRIEND/FAMLY MEMBER

NAME OF PRIMARY DOCTOR_____PHONE _____

EMERGENCY CONTACT_____ PHONE _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: MEDICARE NUMBER:_____
PRIVATE INSURANCE:_____
SUBSCRIBER NUMBER:_____ GROUP NUMBER:_____

COMPREHENSIVE PATIENT HISTORY

Reason for Visit: _____

ALLERGIES: Please list any allergies to medications, tape or latex and describe the reaction that you experience.

	Allergy	**Reaction**
1.	_____	_____
2.	_____	_____
3.	_____	_____

MEDICATIONS: Please list all medications you are taking.

1._____ 3. _____

2. _____ 4. _____

SUPPLEMENTS: List all supplements, vitamins, and herbs you are taking including Vitamin E, Gingko Biloba, Ginseng, and Fish Oil.

_____

_____

MEDICAL HISTORY: Please indicate if you have or had any of the following, followed by a brief explanation if necessary.

			Comments
Heart Disease	☐ Yes	☐ No	
Lung Disease	☐ Yes	☐ No	
Liver Disease/Hepatitis	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
HIV	☐ Yes	☐ No	
Seizure Disorder	☐ Yes	☐ No	
Hypertension	☐ Yes	☐ No	
Bleeding Disorder/Tendency	☐ Yes	☐ No	
Orthopedic Prosthesis/Implant	☐ Yes	☐ No	
Thyroid Disease	☐ Yes	☐ No	
Sleep Apnea	☐ Yes	☐ No	
Syphilis	☐ Yes	☐ No	
Genital Warts	☐ Yes	☐ No	
Gonorrhea	☐ Yes	☐ No	
Herpes	☐ Yes	☐ No	
Other			

SURGICAL HISTORY: Please list any operations that you have and when they were done.

FAMILY HISTORY: Please list any family history of colon, breast, uterine, ovarian, or stomach cancer, colon polyps, Crohn's disease or ulcerative colitis. Please indicate the relationship of each family member listed (mother, father, brother, sister, etc.) and the age of onset.

OBSTERIC/GYNECOLOGIC HISTORY

Number of Pregnancies_____Number of Births_____Number of Vaginal Deliveries_____Number of Caesarean Sections_____

Was an episiotomy performed? _____ Did you have a forceps delivery? _____ Did you have a tear? _____

Did you have a breech baby? _____ What is the size of your largest baby? _____

Have you had any abnormal cervical pap smears? ☐ Yes ☐ No

COLON AND RECTAL HISTORY

How often do you have a bowel movement? _____

Do you ever experience rectal bleeding? ☐ Yes ☐ No _____

Do you have any abdominal pain? ☐ Yes ☐ No _____

Do you have constipation? ☐ Yes ☐ No If so, what do you take for constipation?_____

Do you have diarrhea? ☐ Yes ☐ No _____

Have you ever had a colonoscopy? ☐ Yes ☐ No If so, when? _____

LIFESTYLE

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs a day? _____ How many years? _____

Do you regularly drink wine, beer, or other alcoholic beverages? ☐ Yes ☐ No

If yes, describe type and how often _____

Do you currently or have used recreational drugs? ☐ Yes ☐ No

If yes, describe type and how often _____

REVIEW OF SYMPTONS: Do you suffer from any of the following problems?

Constitutional

☐ Weakness ☐ Anorexia ☐ Night Sweats ☐ Chills ☐ Fatigue
☐ Fever ☐ Weight Gain ☐ Weight Loss ☐ None

Eyes

☐ Blindness ☐ Cataract ☐ Glaucoma ☐ None

Ears/Nose/Throat/Neck

☐ Vertigo Migraines ☐ Hearing Loss ☐ Difficulty Swallowing ☐ Sinus Congestion ☐ None

Cardiovascular

☐ Chest Pain ☐ Shortness of Breath ☐ Abnormal Heartbeat ☐ Exercise Intolerance
☐ Swelling ☐ Fainting ☐ None

Respiratory

☐ Asthma ☐ Cough ☐ Emphysema/COPD ☐ Bronchitis ☐ None

Genitourinary

☐ Urinary Incontinence ☐ Pelvic Pain ☐ Pain with urination ☐ Impotence ☐ None

Musculoskeletal

☐ Arthritis ☐ Back pain ☐ Muscle Weakness ☐ Neck Pain ☐ Joint Pain
☐ None

Dermatologic

☐ Rash ☐ Sores ☐ Skin Growths ☐ Skin Infections ☐ Psoriasis
☐ Shingles ☐ None

Neurologic

☐ Dizziness ☐ Seizure ☐ Memory Loss ☐ Paralysis ☐ Tremor
☐ None

Psychiatric

☐ Alcoholism ☐ Anxiety ☐ Depression ☐ Eating Disorder ☐ Drug Abuse
☐ None

Hematologic

☐ Anemia ☐ Clots ☐ Abnormal Bruising and Bleeding ☐ None

California Colorectal Surgeons

BETH MOORE, MD, FACS, FASCRS
8929 Wilshire Blvd. Suite 302, Beverly Hills, CA
90211 Phone: (310) 854-3580 Fax (310) 659-5830

Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. 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, but not including psychotherapy notes. You must submit your request in writing to our Privacy Officer.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer.

I hereby acknowledge that I have been presented with a copy of Dr. Beth A. Moore, Dr. Zuri Murrell's Notice of Privacy Practices.

Patient Signature: _____

Today's Date: _____

Print Name of Patient: _____

Beth Moore, M.D.

COLON AND RECTAL SURGERY
8929 Wilshire Blvd. Suite 302
Beverly Hills, CA 90211

Phone No: (310) 854-3580 **Email: crmsg402@gmail.com** **Fax No: (310) 659-5830**

INSURANCE COVERAGE / PATIENT PAYMENT AGREEMENT

Please initial **ONLY** the section which most applies to your insurance plan benefits/coverage as indicated by our staff. If you are unsure which of these best applies to you, please leave it blank so we may inform you of your coverage details.

I hereby verify that the staff of the aforementioned office has informed me of the following:

_____ **I currently DO NOT HAVE MEDICAL INSURANCE COVERAGE that can be billed for services to be rendered to me by Dr. Beth Moore.** I understand that I will be responsible for charges **IN FULL ON THE SAME DAY** services are rendered by cash, Visa, or Mastercard prior to leaving their office. I will be provided a receipt of charges. I understand that the above doctors may refer me to outside agencies, specialty practitioners, or specialty care providers that they feel may be necessary for my medical condition, and that I will be responsible for cost(s) for these further testing and consultation with such providers and that they will be billed separately to me.

_____ **Beth Moore MD is OUT-OF-NETWORK and is NOT a participating provider for _____, my medical insurance company.** I understand that I will be responsible to pay for the charges due today prior to leaving the office. I will be provided a receipt of charges, which I can use to personally bill my insurance company. Should the business office of Doctor Moore extend the courtesy of billing my insurance company for office visit(s) and/or surgery charges, I understand that I am primarily responsible for all of Dr. Moore charges, including but not limited to my co-pay, deductible and any difference between Dr. Moore's charges and my insurance company's allowed charges. ***In the event my insurance company sends me the payment for all or any portion of these doctors' charges, I am obligated to immediately remit that check, Dr. Moore's office to be applied against my total charges unless I have already paid Dr. Moore in full for her charges.***

_____ **Dr.Moore is an in-network provider with MEDICARE and BLUE CROSS Policy only.** As a courtesy, the business office of Beth Moore MD will bill my insurance company on my behalf and accept payments based on my in-network benefits - including but not limited to my co-pay, deductible and co-insurance. I understand that I am primarily responsible for all accumulated charges, that I will cooperate in good faith with the business office, and that it is ultimately my responsibility to settle my account should my insurance company deny or delay reimbursement of my charges. ***Should my insurance company send me the payment for all or any portion of Dr. Moore's charges, I am obligated to immediately remit that check to Dr. Moore's office to be applied against my total charges unless I have already paid Dr. Moore in full for her charges.***

Patient Printed Name: _____

Patient Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / PRIVACY POLICY:

I hereby authorize Beth Moore, M.D. to disclose, when requested by the above-named insurance carrier, referring/primary physician(s), and/or its representatives, any and all patient-related information with respect to any illness(es), medical history, or treatment and copies of medical records. A photographic copy of this authorization shall be considered as effective and as valid as the original.

I hereby authorize payments of insurance benefits otherwise payable to me to be made directly to Beth Moore, M.D. I understand that I am ultimately financially responsible for charges not covered by their authorization. I also authorize that a photographic copy of this authorization is as if such copy were the original. If it becomes necessary for the account to be referred to an attorney for collection of suits, the undersigned shall pay all reasonable attorney fees and collection expenses.

A copy of the privacy policy of this office is available for my review in the waiting room.

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____