REALM HEALTHCARE INC. 1330 San Bernardino Rd, Ste L Upland CA 91767
PATIENT INFORMATION

PATIENT NAME (First, MI, Last)	DATE OF BIRTH	GENDER Male Female Other _____
ADDRESS	PRIMARY PHONE	SECONDARY PHONE
EMPLOYER NAME	OCCUPATION	SSN
EMERGENCY CONTACT AND PHONE NUMBER	BIRTHPLACE	PREFERRED LANGUAGE
EMAIL ADDRESS	PHARMACY (Address and Phone)	
PRIMARY CARE PHYSICIAN AND PHONE NO.	REFERRING PHYSICIAN AND PHONE NO.	

Primary Insurance (Please provide Insurance card)

INSURANCE COMPANY NAME	SUBSCRIBER ID#	GROUP #
TYPE OF PLAN: PPO EPO/ HMO / MEDICARE / MEDI-CAL	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH

Secondary Insurance (Please provide Insurance card)

INSURANCE COMPANY NAME	INSURED'S ID#	GROUP #
INSURANCE COMPANY ADDRESS	INSURED'S NAME	INSURED'S DATE OF BIRTH

Release of Health Information

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO INDIVIDUALS: I authorize RHI to disclose and release medical or other information to the below-listed individuals. I understand that this includes, but is not limited to information related to treatment, diagnosis, billing or any health care operations performed at this facility. **I release RHI from all liability pertaining to the release of this information. I understand that this request can be changed at any time through a signed written request.**

_____ _____ _____
Name **Relationship** **Phone Number**

_____ _____ _____
Name **Relationship** **Phone Number**

Authorization and Acknowledgement

AUTHORIZATION: I / We hereby state that the above information is true and correct to the best of my /our knowledge. We authorize RHI to release any information acquired during my treatment to my insurance company, employer, Physicians, institutions or third-party payors, as required for certain claims filed.
_____**Initials**

GENERAL CONSENT: I / We hereby consent to requested procedures including imaging, labwork and endoscopies deemed advisable by RHI. _____ **Initials**

ASSIGNMENT OF BENEFITS STATEMENT: I / We authorize direct payment to be made to the RHI for any and all medical or surgical services rendered. I understand if my insurance carrier does not cover any services or charges or my eligibility cannot be verified, I am responsible for all charges incurred. _____**Initials**

ACKNOWLEDGMENT OR RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that the Notice of Privacy Practices maybe given to me by RHI upon request.
See https://thehealthygut.net/privacy-policy/ **for more information.** _____ **Initials** **[ ] Consent refused by patient. Witness:** _____

☐ **SMS TEXT MESSAGING: I consent to receive SMS from Realm Healthcare Inc. Reply STOP to opt-out; Reply HELP for assistance; Message and data rates apply; Messaging frequency may vary.**

_____ _____ _____
Printed Name **Signature of Patient (or Personal Representative)** **Date**

Screening Colonoscopy: Please sign if you need to schedule a screening Colonoscopy only.

Patients who have screening examinations have no signs or symptoms and have a set benefit from their insurance company. However, if the physician finds a polyp or abnormality, your benefits may change and your insurance policy will pay differently. The colonoscopy is no longer considered a screening procedure, but a diagnostic procedure. I acknowledge that I have read the above statement and will be responsible for my deductible, co-pay and out-of-pocket expenses if my scheduled screening examination does find a polyp or abnormality.

_____ _____ _____
Printed Name **Signature** **Date**

REALM HEALTHCARE INC.

PATIENT FINANCIAL RESPONSIBILITY POLICY

We appreciate your confidence and goodwill. To ensure that we have financial stability and can continue to provide medical services to the community, the following policies shall be enforced:

Correct Insurance Information: You are responsible for providing us with correct and updated information about your health insurance. It is your responsibility to notify us immediately of any changes to your health insurance plan or insurance status. If we have incorrect insurance information, outstanding balances will be billed to you directly.

Eligibility Waiver: If verification of your coverage for health plan benefits cannot be made at this time, services will still be provided to you. However, in the event your coverage is not active, you will be held responsible for payment of services.

Non-Covered Services: Know your insurance benefits before each visit. You will be asked to pay for any services that are not covered by your insurance plan. All charges are due and payable at the time of services. We may reschedule the appointment if payment is not made prior to the services rendered. Realm Healthcare Inc. will submit claims for services to your insurance carrier. When an insurance carrier is required to pay Realm Healthcare Inc. for a service that has been provided, you are only responsible for what is considered the patient portion of the claim. However, if your insurance carrier rejects, delays, withholds, denies payment of its portion or covers only a portion of treatment for more than 90 days from the date of service, both the insurance and patient portions of your account then become your responsibility. If we subsequently receive payment from your insurance carrier, we will credit your account for the amount of the payment.

Medicare Part B **IS NOT** covering **ROUTINE** colonoscopies for patients between the ages of 65-75. If you wish to schedule a colonoscopy, you will be charged **$250.00** **UPFRONT** for the doctors fee. Once Medicare pays the claim, **THIS AMOUNT** will be promptly **REFUNDED**.

No-Show and Cancellation Policy: If you fail to cancel your procedure/ office appointment at least 24-48 hours in advanced with Realm HealthCare Inc., you are responsible for a $50 fee which will not be applied to any co-pay, deductible or coinsurance. Patients who cancel/ reschedule with less than a 48 hour notice, or do not show for procedure/ office appointments on 2 occasions, will not be scheduled in the future and will have to find another specialist for their care.

HMO Insurance: All HMO patients must obtain a valid referral prior to the appointment. If you do not obtain a referral from your primary care physician prior to receiving services or a Referral cannot be verified by our office, our office will re-schedule your appointment.

Legal Guardian/ Conservator: The patient's legal guardian or conservator (if an incapacitated adult) is responsible for the payment of co-pays, co-insurance, deductibles, and all procedures or treatments not covered by their insurance plan.

Delinquent/ Unpaid Account: Prior to providing services, payment of prior outstanding accounts may be requested and should be received. Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically urgent. Accounts which cannot be collected within 90 days from the 1st statement date by the physician after normal in-house collection procedures, may be referred to a collection agency, magistrate, or attorney for further collection action.

Administrative Charges: Patients may incur, and are responsible for the payment of additional charges at the discretion of Realm Healthcare Inc. These include:

- A **3% Credit/ Debit Card Processing Fee**. We will keep the card on file but will we will notify you prior to processing any payments. There will be ***NO*** **3%** Processing Fee ***IF*** paying with ***CASH*** or ***CHECK***.
- Charge for copying/ printing & distribution of patient medical records is $25.00. Requests will be completed within 10 business days.
- Charge for writing a letter or forms completion, including but not limited to disability and FMLA forms is $35.00.

Third Party Litigation: Our physician will not become involved in disputes arising from third party claims (i.e. automobile accidents, liability claims, etc.).

I hereby authorize assignment of financial benefits directly to Realm Healthcare Inc. and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment. I understand that account balances not paid by the insurance plan are the patient/ legal guardian/ conservator's responsibility. I also understand that account balances not paid within 90 days from the 1st statement date may be sent to a collection agency.

I, the patient/patient's legal representative, understand and agree to abide by the financial policy and provisions outlined in this Patient Financial Responsibility Policy.

Printed Name of Patient	Signature	Date

NISCHITA MERLA, M.D.

Health Questionnaire *(Cuestionario de Salud)*

NAME *(Nombre)*: _____ **AGE** *(Edad)*: _____ **years** *(años)*

REASON FOR VISIT *(Razón de la visita)*: _____

Check all that apply *Marque todo lo que corresponda*

GENERAL

- ☐ Loss/gain of weight *Pérdida/ ganancia de peso*
- ☐ Loss of appetite *Pérdida del apetito*
- ☐ Fevers, chills *Fiebres, escalofríos*
- ☐ Fatigue, weakness *Debilidad, fatiga*

HEENT/ NECK

- ☐ Yellowing of eyes *Ojos amarillentos*
- ☐ Neck stiffness *Rigidez en el cuello*
- ☐ Nosebleeds *Las hemorragias nasales*

SKIN

- ☐ Bruises *Moretones/Contusiones*
- ☐ Rash *Erupción*

CARDIORESPIRATORY

- ☐ Cough *Tos*
- ☐ Shortness of breath *Falta de aliento*
- ☐ Wheezing/ asthma *Las sibilancias/ asma*
- ☐ Chest pain *Dolor en el pecho*
- ☐ Sleep apnea *Apnea del sueño*
- ☐ Irregular heart beat or palpitations *Latido cardíaco irregular o palpitaciones*
- ☐ Snoring *Ronquido*
- ☐ Swelling of feet *Hinchazón de los pies*
- ☐ Frequent night-time awakenings *Frecuentes despertares en la noche*

GENITOURINARY

- ☐ Blood in urine *Sangre en la orina*
- ☐ Difficulty urinating *Dificultad para orinar*

GASTROINTESTINAL

- ☐ Abdominal pain *Dolor abdominal*
- ☐ Nausea or vomiting *Náusea o vómito*
- ☐ Difficulty swallowing *Dificultad para tragar*
- ☐ Blood in stool *Sangre en las heces*
- ☐ Pain during defecation *Dolor durante la defecación*
- ☐ Diarrhea or constipation *Diarrea o estreñimiento*
- ☐ Change in bowel habits *Cambio en los hábitos intestinales*
- ☐ Liver trouble *Problemas del hígado*
- ☐ Hemorrhoids *Hemorroides*

GYNECOLOGIC

- ☐ Pelvic pain *Dolor pélvico*
- ☐ Prior C-sections *Cesáreas anteriores*

NEUROPSYCHIATRIC

- ☐ Dizziness *Mareo*
- ☐ Headaches *Dolores de cabeza*
- ☐ Loss of consciousness *Pérdida de la conciencia*
- ☐ Seizures *Convulsiones*
- ☐ Depression *Depresión*
- ☐ Anxiety *Ansiedad*

MUSCULOSKELETAL

- ☐ Muscle pain *Dolor muscular*
- ☐ Joint stiffness *Rigidez en las articulaciones*

PAST HISTORY: Have you ever been diagnosed with the following? *¿Alguna vez ha sido diagnosticado con los siguientes?*

☐ Anemia *Anemia*	☐ Angina *Angina de pecho*	☐ Heart disease *Enfermedad del corazón*	☐ Pancreatitis *Pancreatitis*
☐ Cancer *Cáncer*	☐ Sleep apnea *Apnea del sueño*	☐ Depression/ anxiety *Depresión/ ansiedad*	☐ Hepatitis *Hepatitis*
☐ Ulcer *Úlcera*	☐ Hypertension *Hipertensión*	☐ Ulcerative Colitis/ Crohn's *Colitis ulcerosa/Crohn's*	☐ H. pylori infection *Infección de h. pylori*
☐ Diabetes *Diabetes*	☐ Colon Polyps *Pólipos en el colon*	☐ Diverticulosis *Diverticulosis*	☐ Hiatal Hernia *Hernia hital*
☐ Stroke *Derrame cerebral*	☐ Valvular disease *Enfermedad valvular*	☐ Liver disease/ Cirrhosis *Enfermedad hepatica/cirrosis*	☐ Bleeding disorder *Desorden sangrante*
☐ Cardiac stent/PCI *Stent cardiaco*	☐ Autoimmune disease *Enfermedad autoinmune*	☐ Renal disease/ Dialysis *Enfermedad renal/ diálisis*	☐ Hemorrhoids *Hemorroides*
☐ Asthma/ COPD *Asma/ EPOC*	☐ Jaundice *Ictericia*	☐ Seizures *Convulsiones*	

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FAMILY HISTORY: *¿Alguien en su familia ha tenido alguna de las siguientes condiciones: ?*

	Mother *Madre*	Father *Padre*	Siblings *Hermanos*	Other *Otros*
Anemia *Anemia*				
Peptic ulcer *Úlcera péptica*				
Cancer *Cáncer*				
Polyps *Pólipos*				
Diarrhea *Diarrea*				
Rectal bleeding *Sangrado rectal*				
Liver disease *Enfermedad hepática*				
Colitis/Crohn's *Colitis/ Crohn's*				

Any ALLERGIES to: medication, food, and/ or reaction to previous blood transfusion? *¿Tiene alguna alergia a: medicamentos, y/ o alimentos? ¿Reacción a la transfusión de sangre anteriormente?*		☐**No**	☐**Yes** *(si)* _____
Have you had any surgeries? *¿Ha tenido cirugías?*		☐**No**	☐**Yes** *(si)* _____
Any prior reactions to anesthesia? *¿Reacción a la anestesia anteriormente?*		☐**No**	☐**Yes** *(si)* **Reaction** *Reacción* _____
Are you using or have you ever used: *Utiliza o ha utilizado:*	**Alcohol** *Alcohol*	☐**No**	**Drinks: Per day** *Bebidas: Al dia* _____ **Per week** *Por semana* _____
	Tobacco (cigarette) *Tabaco (cigarrillo)*	☐**No**	☐ **Yes** (Current) **Packs per day** *Paquetes al dia* _____ **Years of use** *Años de uso* _____ ☐**Ex-smoker:** **Packs per day** *Paquetes al dia* _____ **Years of use** *Años de uso* _____
	Recreational drugs *Las drogas recreativas*	☐**No**	☐**Yes** *(si)* _____
Any prior procedures? *¿Procedimientos anteriores?*	☐**Endoscopy** *Endoscopia*	☐**No**	☐**Year** *Año* _____ **Findings** *Resultados* _____
	☐**Colonoscopy** *Colonoscopia*	☐**No**	☐**Year** *Año* _____ **Findings** *Resultados* _____

LIST MEDICATIONS/ VITAMINS *Indique sus medicamentos/ vitaminas*