



Liver Disease Questionnaire (LDQ)

Please complete this form with the information requested for evaluation at the Physician Foundation at California Pacific Medical Center. Although some of the information requested may be personal, this history is necessary for a thorough evaluation of your liver disease and risk factors.

Provider:

___ Maurizio Bonacini, M.D.
___ Natalie Bzowej, M.D., PhD
___ Stewart Cooper, M.D.
___ Robert Gish, M.D.

___ Catherine Frenette, M.D.
___ Raphael Merriman, M.D.
___ Adil Ed Wakil, M.D.
___ R. Todd Frederick, M.D.

___ Tammy Lee, N.P.
___ Marice Thomas, N.P.
___ Tim Davern, M.D.

Name:	Last	First	Middle		
Address:	Street	Apt. #	City	State	Zip Code
() _____ Home Phone	() _____ Work Phone	ext. _____	() _____ other phone (cell/pager)		
() _____ Fax Number	_____ Email Address		_____ Birthdate (MM/DD/YYYY)		
() _____ Emergency Contact Person (Tel# and Name)	() _____		English Speaking Contact (Number and Name)		
_____ - _____ - _____ Social Security #	_____ Age	_____ Gender (M/F)	_____ Marital Status		
_____ Employer's Name			_____ Occupation		

<p>Primary Care Physician/ Other MD (This information must be complete and current)</p> <p>Name: _____</p> <p>Address: _____ _____</p> <p>Phone: () _____ FAX _____</p>

<p>Gastroenterologist (This information must be complete and current)</p> <p>Name: _____</p> <p>Address: _____ _____</p> <p>Phone: () _____ FAX _____</p>

I give my consent to release my medical information to the physicians listed above and other doctors involved in my care.

Signature _____

Date _____

Provider Signature and Date: _____

Insurance Information

Primary Insurance: _____

Insured's Name: _____

ID #: _____ GROUP #: _____

Authorization # for this visit*: _____

*If you do not provide an authorization number and this is required by your insurance plan, you will be responsible for payment.

Address of Insurance Company:

Secondary Insurance: _____

Insured's Name : _____ Relationship to patient: _____

ID #: _____ GROUP #: _____

Address of Secondary Insurance Company:

I hereby authorize payment directly to the physician on my behalf for services provided to me. I understand that I am ultimately responsible for fees for professional services as well as any non-covered services provided. I authorize the physician to release all information necessary to secure the payment of benefits.

Patient Signature (or parent if minor)

Date

1. Background Today's date: _____ Date of your appointment: _____

Height: _____ Weight: _____ Weight at age 18? _____ What is your waist size: _____

What diagnosis have you been given? _____

What is *your* main reason for your visit here? _____

2. Review of Systems

Have you suffered from any of the following in the last three months? Please circle Yes or No.

Condition	Yes	No	Intensity		Duration In days or months
			Mild	Moderate Severe	
Fevers, chills or sweats	Yes	No			
Memory problems	Yes	No			
Trouble concentrating	Yes	No			
Migraine headaches	Yes	No			
Sleeping problems	Yes	No			
Night blindness	Yes	No			
Diarrhea	Yes	No			
Dry mouth or eyes	Yes	No			
Constipation	Yes	No			
Blood in bowel movements	Yes	No			
Abdominal pain	Yes	No			
Weight loss	Yes	No			
If yes, how much weight have you lost in the last year? _____			Reason for weight loss? _____		
Fatigue	Yes	No			
Joint aches	Yes	No			
Muscle aches	Yes	No			
Itching	Yes	No			
Leg swelling	Yes	No			
Sores on your skin	Yes	No			
Muscle loss	Yes	No			
Loss of sexual interest	Yes	No			
Sexual difficulties	Yes	No			
Chest pains	Yes	No			
Shortness of breath	Yes	No			
Urine symptoms	Yes	No			

MD Signature _____ Date _____

6. Family History

Has any blood relative ever had any of the following? Circle yes or no and if yes, indicate who:

Condition	Yes	No	Relationship (who in your family)
Liver disease (hepatitis, cirrhosis)	Yes	No	
Liver cancer (hepatocellular carcinoma)	Yes	No	
Hip fracture or Osteoporosis (circle)	Yes	No	
Colon cancer	Yes	No	
Breast cancer	Yes	No	
Emphysema	Yes	No	
Diabetes	Yes	No	
Depression/Psychiatric disease	Yes	No	
Alcoholism	Yes	No	
Lupus or rheumatoid arthritis (circle)	Yes	No	
Heart attacks before the age of 60	Yes	No	
Other:			

7. Personal and Social History

What is your ethnic/race background? _____

Where (in what country) were you born? _____

Where were your parents born? _____

Number of children (if any): _____

To what foreign countries have you traveled? _____

Number of sexual partners in your lifetime: <10 10-20 20-50 >50

Sexual preference: (circle one) male female both

If you get sick, who would help take care of you? _____

Please provide the following information (circle yes or no and provide the details indicated):

Personal History		
Work:		
Are you working?	Yes	No
If yes, what do you do?		
Are you on disability?	Yes	No
If yes, for what diagnosis?		
Is your disability: State SSI Social Security		
Tobacco:		
Have you ever smoked?	Yes	No
If yes, for how many years? _____ Number of packs per day? _____		
If yes, do you still smoke?	Yes	No
If no, when did you quit? Date _____		
Blood Products:		
Have you had blood, blood products, or globulin exposure/transfusions?	Yes	No
If yes, when? Type of product:		
If yes, reason for transfusion		
Have you ever been stuck by a needle in the work setting?	Yes	No
Do you have any tattoos/body piercings? _____		

Alcohol:		
Do you currently drink alcohol?	Yes	No
Number of drinks per day_____ Number of days per week_____ Type_____		
If No, when was your last drink? Date_____		
Have you ever had alcohol negatively influence your work or personal life?	Yes	No
Have you ever had a DUI (driving under the influence) ticket?	Yes	No
Have you ever tried to cut down on the amount that you were drinking?	Yes	No
Have you ever felt annoyed when people asked about your drinking?	Yes	No
Have you ever felt guilty about your drinking?	Yes	No
Have you ever had an "eye-opener" drink, first thing in the morning?	Yes	No
Street Drugs:		
Have you ever used drugs? (cocaine, marijuana, uppers, downers, LSD, etc)	Yes	No
Have you ever snorted drugs?	Yes	No
Have you ever used IV needles? (non-medical injections)	Yes	No
If yes, what was the first date used?		
If yes, what was the last date used?		
When was your last experience with any drugs? Date:		
Have you ever been in jail or prison?	Yes	No
Have you ever attended Alcoholics or Narcotics Anonymous?	Yes	No
If yes, why did you go to NA or AA?		

8. Psychiatric History

Condition	Yes	No
Have you ever been diagnosed with depression?	Yes	No
Have you ever been treated for depression?	Yes	No
Have you ever been hospitalized for a psychiatric illness?	Yes	No
Have you ever attempted suicide?	Yes	No
Do you feel suicidal now?	Yes	No
Do you have a feeling of hopelessness?	Yes	No
Do you describe yourself as anxious? (at times or consistently?)	Yes	No
Have you ever been diagnosed with any other psychiatric disease?	Yes	No
Details:		

CES-D Scale

(Department of Health and Human Services, National Institute of Mental Health)

Circle the number for each statement that best describes how often you felt or behaved this way during the past week.

DURING THE PAST WEEK	RARELY OR NONE OF THE TIME (LESS THAN 1 DAY)	SOME OR A LITTLE OF THE TIME (1-2 DAYS)	OCCASIONALLY OR A MODERATE AMOUNT OF TIME (3-4 DAYS)	MOST OR ALL OF THE TIME (5-7 DAYS)
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people dislike me.	0	1	2	3
20. I could not get "going."	0	1	2	3

ACKNOWLEDGMENT OF POLICIES AND PROCEDURES

This form acknowledges that you have read and understand the policies as outlined on the following pages. Please read these carefully, and initial each section below that you have read them. The following pages should be removed from this packet and are yours to keep for your reference.

_____ Financial Responsibility

_____ Our Practice

_____ Toxicology Screens

_____ Medical Records

_____ Our Fees

_____ Patient Contacts

_____ Confidentiality Notice

_____ Financial Policy

I have read this Policy Statement and agree to the terms as stated in the following pages. I further agree that I will be personally and fully responsible for payment of any services determined to be “non-covered” or a “non-benefit” by my insurance company.

Patient Name

Patient Signature

Date



Physician Foundation
at California Pacific
Medical Center

A Sutter Health Affiliate

Financial Responsibility for Payment

PATIENT: (print name of patient) _____

I understand that I am financially responsible for any balances following contractual adjustment or not covered by my insurance. Further, I certify that I have disclosed all insurance coverage available for the above named patient and or dependent. If there are changes in coverage I will inform the office of the above physicians of such changes.

In the event it is determined that I am not eligible for services on or if I voluntarily elect to seek treatment from an "out of network provider" of my plan, that I will be held financially responsible for all charges incurred by me or my non-covered dependent. A photocopy of these assignments shall be valid as the original.

Release of Medical Information

I further, (print patient's name) _____ (or guardian of), hereby authorize the following physicians (s) and/or institution(s) to release information obtained during the course of my diagnosis and treatment to the Physician Foundation at California Pacific Medical Center. Further, I hereby authorize the Physician Foundation at California Pacific Medical Center to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that this agreement will be in effect until I revoke it in writing. A photocopy of these authorizations shall be valid as the original.

MY SIGNATURE BELOW REFLECTS AUTHORIZATION OF THE ABOVE:

X _____ Date: _____

Relationship to Patient: _____

TEAR THESE SHEETS OFF AND KEEP FOR YOUR RECORDS

OFFICE INFORMATION FOR PATIENTS

Our Practice: Thank you for choosing us as a provider for your Hepatology & Gastroenterology health care needs. We are committed to working with you to achieve a successful treatment outcome. However, unfortunately we cannot guarantee to you that clinical improvements can be made. Please ask the office staff if you wish to see a physician's C.V. / resume. You may be seen by an associate in the group if the primary physician you are scheduled with has an emergency and must change his/her schedule. If you wish to have an estimate of cost of your consultation, please notify the medical assistant before you see the physician. Telephone consultations are used only in special situations. You or your insurance company must be able to pay for the consult and this telephone consult has to be prearranged, authorized and approved by your practitioner.

Toxicology Screens: Our policy is to perform random alcohol and toxicology screens where indicated by the doctor managing your care. This information is confidential and will only be released if there is written permission, from you the patient.

Your Medical Records: Please bring all medical records with you when you come for an initial appointment; do not depend on your physician's office to mail these records. You have access to your medical chart in our offices and we encourage you to keep copies for your own records. If you need any specific written medical information, please ask the front office staff and they will direct you to our medical records department. The best time to reach our office staff is between 8:00 a.m. and 4:30 p.m. If you must leave a message, please indicate a specific time when you may be reached. The staff will make all attempts to contact you the same day you call, but please have patience if a call is not returned immediately.

Your Initial Visit: The following will be included in your initial consultation:

- 1) Medical history and physical exam
- 2) Communication by letter to your primary medical doctor concerning the initial visit findings and recommendations.
- 3) Information booklets or handouts regarding your disease, if available.
- 4) Review of previous medical records
- 5) Analysis of current and previous laboratory information

Additionally, you will be billed separately for review and reading of any liver biopsy you may present.

Our Fees: UCR (Usual and Customary Rates)

We charge what is usual and customary for our specialty and geographic area. Unless we are contracted with your HMO or PPO, you are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates.

Patient Contacts: It is the policy of our practice to reserve the right to charge for phone calls, e-mails, conferences, letters and faxes to our patients. These are important modes of communication between our physicians and patients that cover issues pertaining to patient care previously discussed as well as new and expanded issues not part of any previous visit. The charges made for these patient contacts depend upon the time spent with the physician and the type of service provided. Emails are kept confidential but may not be transmitted by secure server and by signing this form you agree to the terms of this communication process.

CONFIDENTIALITY NOTICE: E-MAIL MESSAGES, INCLUDING ANY ATTACHMENTS, IS FOR THE SOLE USE OF THE INTENDED RECIPIENT (S) AND MAY CONTAIN CONFIDENTIAL AND PRIVILEGED INFORMATION. ALTHOUGH UNLIKELY, EMAIL SENT VIA THE INTERNET MAY BE INTERCEPTED BY THIRD PARTIES. HENCE, THE PRIVACY OF HEALTHCARE DATA CANNOT BE COMPLETELY ASSURED. **IF YOU ARE A PATIENT: A COPY OF THE PATIENTS' HIPPA-RELATED PRIVACY RIGHTS IS IN EACH PATIENTS CHART. PATIENTS WHO CHOOSE TO COMMUNICATE VIA EMAIL THUS ACKNOWLEDGE RECEIPT OF THIS DOCUMENT AND CONSENT TO EMAIL EXCHANGE WITH THE RECOGNITION THAT HIPPA-RELATED PRIVACY RIGHTS CANNOT BE GUARANTEED. FURTHER QUESTIONS MAY BE DIRECTED TO OUR HIPPA COMPLIANCE OFFICER AT 415-379-9600. IF EMAILS REACH**

THE WRONG RECIPIENT, PLEASE CONTACT US VIA RETURN EMAIL OR AT OUR OFFICE NUMBER OR THE ABOVE TELEPHONE NUMBER AND DELETE ANY INFORMATION RECEIVED.

YOUR INSURANCE COMPANY MAY NOT PAY FOR THESE SERVICES BECAUSE THEY ARE NON-COVERED OR A NON-BENEFIT OF THE PARTICULAR PLAN YOU HAVE WITH THE INSURANCE COMPANY. IN THAT CASE, WE ASK THAT YOU BE PERSONALLY RESPONSIBLE FOR PAYMENT OF THESE COMMUNICATION SERVICES IN THE EVENT A CHARGE IS SUBMITTED.

Our Financial Policy:

Please remember that payment of your bill is considered a part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask our billing department if you have any questions about fees or our Financial Policy.

- All patients must complete our “Patient Registration Form”
- Full payment for your share of the charge is due at the time of service
- We accept cash, check and MasterCard/Visa as forms of payment

All services provided by this office will be billed. If you do not have insurance or your insurance does not cover treatment processes or medications, you should notify us so adjustments can be made or attempts at obtaining discounted medications can be initiated.

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible only for the difference between the approved charge and the amount Medicare pays. If you have a supplemental insurance we will bill them directly for you. You will receive a bill after the insurance has paid.

HMO/PPO: ALL COPAYMENTS ARE DUE AT TIME OF SERVICE. IF YOU DO NOT KNOW YOUR COPAY YOU MAY USE OUR PHONE TO CALL AND FIND OUT. We are members of a number of HMOs. Patients will not be billed for more than their copayment as long as we have the necessary referrals. PPO patients will only be responsible for their copayment and/or coinsurance as long as they have verified with their insurance that our physician is in their plan. If our physician(s) is not part of your health plan, you are asked to sign the attached Financial Responsibility Payment Form.

Prior Authorization of Visits: Your insurance company may require authorization prior to your initial visit. Please be aware that if they do, it is the patient’s responsibility to obtain this authorization, and you may be charged for any initial visit that does not have prior authorization, but requires one.

Workers’ Compensation: Patients being seen as a result of a work related injury are still responsible for charges incurred by them. At the time of your visit, we will attempt to verify coverage of your charges by your employer. If we cannot verify coverage, we will bill you directly for your charges. Also, if your employer does not pay for your charges within a reasonable period of time, we will bill you directly.

Cancellation/No show policy: Your appointment time has been reserved exclusively for you. If you fail to cancel your appointment at least 24 hours in advance, you may be billed for a cancellation fee. If you do not come to your scheduled appointment you may be billed for a no-show fee. Insurance companies do not cover missed appointments or cancellation fees.

Filing insurance claims: In order to file a claim on behalf of the patient, we must have a copy of the insurance I.D. card and the complete address of where the claim is to be sent. Without this information, you will be billed directly. We will be glad to submit your insurance claims to your carrier, at no cost to you. However, we are not in a position to guarantee payment from your insurance company since the claim is based upon arrangements between you and the insurer. You will be asked to sign an agreement to pay for services for which the insurance does not pay any benefits. We file claims for Medicare, Public Aid (Medicaid/Medi-Cal), HMO/PPO’s Workmen’s Comp and indemnity insurance.

Questions about your bill should be directed to the Sutter Health Customer Service Department at (800) 470-0071