DENVER ENDOSCOPY CENTER, LLC

Name: _____ Sex: M F

Address: _____City: _____State: ____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Home Phone: (____)_____ Cell Phone: (____)_____

Employer: _____ Business Phone: (____)_____

Employer's Address: _____

Marital Status: _____ Spouse/Partner/Significant Other's Name: _____

Emergency Contact: _____ Relation of Contact: _____

Home Phone: (____)_____ Cell/Business Phone: (____)_____

Referring Physician: _____ Primary Care Physician: _____

MEDICAL INSURANCE INFORMATION Retired? Y N

Primary Insurance Company: _____Phone Number_____

Policy/ID Number: _____ Group Number: _____

Policy Holder: _____Your relationship to the Policy Holder: _____

Secondary Insurance Company: _____Phone Number_____

Policy/ID Number: _____ Group Number: _____

Policy Holder: _____Your relationship to the Policy Holder: _____

POLICY HOLDER INFORMATION

Name: _____ Date of Birth: _____

Address: _____City: _____State: ____ Zip: _____

Social Security Number: _____ Occupation:__ _____

Home Phone: (____)_____ Cell Phone: (____)_____

Employer: _____ Business Phone: (____)_____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to the Denver Endoscopy Center where services were provided. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible to the Center for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees, should this be required.

_____ _____

Signature Date

Denver Endoscopy Center

PATIENT HISTORY

Name: _____ Date of Birth: _____

Age: _____ Referring/Primary Care Physician: _____

A) REASON FOR VISIT

_____

_____

How does this affect your lifestyle? _____

Increased Appetite? Yes _____ No _____

Decreased Appetite? Yes _____ No _____

Recent Weight loss? Yes _____ No _____

Recent Weight gain? Yes_____ No_____

If "yes" to weight change, how much over what length of time_____

Prior problems with anesthesia? Yes___ No _____

If "yes", please describe_____

_____

B) PATIENT PROFILE (CIRCLE ONE)

Married Divorced Single Separated Widowed

Have you had a sigmoidoscopy or barium enema?

____ No ____ Yes; Date of test _____

Last medical examination _____

Occupation: _____

Years retired: _____Since _____

Hobbies/Interests _____

Smoking: Pipe_____Cigarettes _____

Chewing Tobacco_____ Marijuana_____

Recreational Drug Use _____

Coffee: More than two cups per day _____

Alcohol: _____ _____glasses per day

_____

Beer/Wine:_____ _____glasses per day

_____

C) MEDICATION ALLERGIES _____

_____

_____

Patient Signature

_____

Nurse Signature Indicating Review

D) HOSPITALIZATION AND/OR SURGERIES

_____

_____

E) Do you have pain now or have you had pain in the last several weeks? Yes___ No___ If yes, how would you rate the level of pain on a scale of 1-10 with 10 being the worst? _____ Describe the pain. Where is it located? What aggravates it? What alleviates it? How long does it last?_____

_____

_____

_____

_____

F) MEDICINES

Please list all medicines taken daily or routinely, with or without prescriptions, including birth control bills, vitamins, aspirin, pain pills, herbal and/or dietary supplements

_____Dosage_____Frequency _____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

_____Dosage_____Frequency_____

G) MEDICAL HISTORY (Please Circle)

High Blood Pressure, Heart Disease, Diabetes,
Kidney Problems, Liver Disease, Arthritis, Breathing Difficulty
Vision Problems, Stroke, Seizures, Hearing Difficulty
Other _____

_____

_____ _____

Date Time

_____ _____

Date Time

Colorado Gastroenterology Prof LLC and Denver Endoscopy Center
Disclosure and Consent for Medical and Surgical Procedures

To the Patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This decision is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to this procedure.

I (we) voluntarily request: **__ Jeffrey Frank, M.D.** **__ Kevin Sieja, M.D.** **__ Thomas Trouillot, M.D.**
__ Kevin Rufner, M.D. **__ Jennifer Brenner, M.D.**

as my physician, and such associates, technical assistants and other health care providers as he may deem necessary to treat my condition, which has been explained to me as:

_____

and understand that alternatives include, but are not limited to, barium enema, upper gastrointestinal series, _____.

I (we) understand the following surgical, medical and/or diagnostic procedure(s) are planned for me and I (we) voluntarily consent and authorize these procedures:

__Esophagogastroduodenoscopy with possible biopsy and/or polypectomy and/or dilation
__Colonoscopy with possible biopsy and/or polypectomy and/or dilation
__Flexible Sigmoidoscopy with possible biopsy and/or polypectomy and/or dilation
__Other_____

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) understand that no warranty, guarantee or assurance has been made to me as to the results of the procedure and that it may not cure my condition. Although colonoscopy is highly recommended for colon cancer prevention, I understand that it is no guarantee to eliminate the risk of developing colon cancer.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:
__Drug reaction __Bleeding __Perforation __Infection __Cautery Burn __Cardiac Arrhythmia __Aspiration

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize that anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetics including respiratory problems, drug reactions, paralysis, brain damage and even death.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I understand its contents.

_____	_____	_____
Date	**Time**	**Patient and/or Legal Guardian Signature**
_____	_____	_____
Date	**Time**	**Witness Signature**
_____	_____	_____
Date	**Time**	**Physician Signature**

FINDING YOUR WAY TO THE:

DENVER ENDOSCOPY CENTER
8155 E. 1st Avenue
Denver, CO 80230

From Alameda Ave

- Go NORTH on Fairmount Drive (between Quebec and Havana) to Lowry Blvd.
- Turn RIGHT and go to the 2nd round-about
- Turn LEFT on Uinta Way
- Turn LEFT on E. 1st Avenue – go approximately ½ block
- 8155 E. 1st Avenue will be to your right

Quebec St

- Go EAST on Lowry Blvd (between Alameda and Sixth Ave) through 2 round-abouts to Uinta Way
- Turn LEFT on Uinta Way
- Turn LEFT on E. 1st Avenue – go approximately ½ block
- 8155 E. 1st Avenue will be to your right

From I-25

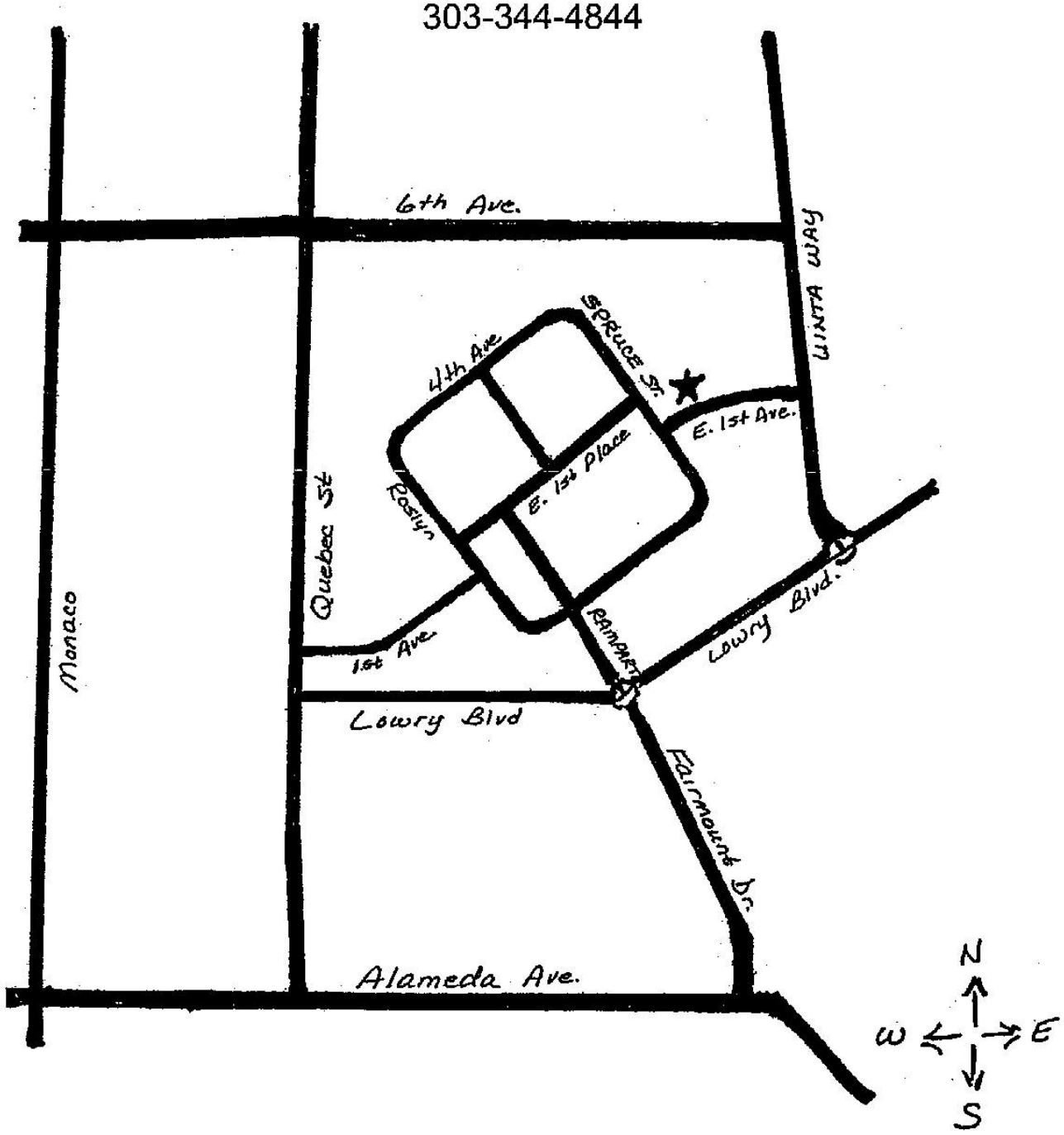
- EXIT on Sixth Avenue (eastbound) – go approx 5 miles, passing Colorado Blvd and Quebec St
- Turn RIGHT on Uinta Way – go approximately 3 blocks
- Turn RIGHT on E. 1st Avenue – go approximately ½ block
- 8155 E. 1st Avenue will be to your right

From I-225

- Take Alameda exit and go west about 4 miles.
- Go NORTH on Fairmount Drive (between Quebec and Havana) to Lowry Blvd.
- Turn RIGHT and go to the 2nd round-about
- Turn LEFT on Uinta Way
- Turn LEFT on E. 1st Avenue – go approximately ½ block
- 8155 E. 1st Avenue will be to your right

Denver Endoscopy Ctr, LLC
8155 E. 1st Ave.
Denver, CO 80230

303-344-4844



Denver Endoscopy Center, LLC

8155 East 1st Avenue
Denver, CO 80230

PATIENT'S RIGHTS

Every patient has the right to be treated fairly, with respect and as an individual.

Patients are treated with respect, consideration, and dignity.

Patients are provided appropriate privacy.

Patient disclosures and records are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse of their release.

Patients are informed of their right to formulate an advanced directive, at the time of admission, and to appoint a designated representative to make health care decisions on their behalf to the extent permitted by law.

Patients may elect to refuse treatment with regards to the facility policy of NOT HONORING Advance Directives. The facility will make every effort to inform the patient of alternative facilities for treatment.

The physician who refers patients to our center may have an ownership interest in this facility. Patients are free to choose another facility in which to receive services.

Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

Patients are provided information about treatment alternatives and will be advised of the advantages and disadvantages of each.

Patients have the right to refuse to participate in experimental research.

Patients have the right to know in advance the type and expected cost of treatment.

Patients have the right to be informed of the professional rules, laws and ethics that govern the organization and its employees.

Patients and families have the right to express grievances and suggestions to the organization. Every effort will be made to follow up on all grievances and suggestions. Patient care and satisfaction are very important to our entire staff.

PATIENT RESPONSIBILITY AND CONDUCT

To provide the health care providers with information about any past illnesses, hospitalizations, medications and other health matters.

To ask questions if they do not understand instructions or explanations given by the healthcare providers and/or staff.

To keep appointments as scheduled and to telephone the office in case of cancellation.

To follow health care providers instructions and plan of treatment.

To make payments for services rendered if a balance remains after insurance pays.

To discuss consequences of refusing treatment or not adhering to plan of treatment or leaving AMA, with their physician. (See Discontinuing Treatment with Problem Patient.)

To refuse to participate in experimental research, care from a student or trainee, if that is their desire.