

Date \_\_\_\_\_

## Patient Information

Thank you for choosing our office! In order to serve you well, we need the following information. Please print. All your medical information will be kept confidential.

### Patient Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Person to contact in an emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Primary Care Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

### Insurance Information

#### Primary Insurance

Insurance Company \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder (if other than patient) \_\_\_\_\_ Birthdate \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Employer of Policy Holder \_\_\_\_\_  
Address \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell \_\_\_\_\_ SS# \_\_\_\_\_

#### Secondary Insurance

Insurance Company \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder (if other than patient) \_\_\_\_\_ Birthdate \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Employer of Policy Holder \_\_\_\_\_  
Address \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell \_\_\_\_\_ SS# \_\_\_\_\_

### Assignment of Benefits and Authorization for Release of Information

I authorize release of any information concerning my or my child's health care, advice and treatment provide for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits directly to my physician. I am financially responsible for non-covered expenses.

We are committed to providing you with the best possible care. As a service to you, we will file your insurance claim with necessary information in a timely fashion. Any balances after insurance pays will be billed to you for payment.

Please remember that your contract is between you and your insurance company to provide reimbursement for medical care. We cannot be responsible for unwarranted delays by your insurance company or HMO. If your coverage is not what you expect, please discuss it with insurance company or employer.

Most insurance policies will not cover the entire expense for your care. Please pay you co-pay at time of check out. In most cases, you will be required to make a deposit at the time you surgery is scheduled. For your convenience, we accept cash, checks, and most major credit cards.

### Acknowledgement of Receipt of Privacy Notice

I understand that my physician or staff may share my / my child's medical information for treatment, billing, and healthcare business purposes. I acknowledge that I have been given information that describes how my / my child's medical information is used and shared.

**X** Signature of patient/parent \_\_\_\_\_ Date \_\_\_\_\_

*This signature is valid from this date and continues until revoked.*

**Patient History**

Name \_\_\_\_\_

Birthdate \_\_\_\_\_

Reason for being here \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

**Allergies** \_\_\_\_\_

Latex Allergy ( ) Yes ( ) No

What allergic reaction did you have to the above \_\_\_\_\_

**Current Medications / Vitamins / Herbs****How much?****How often?**


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Name of Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**Ongoing Health Problems** \_\_\_\_\_

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**Previous Surgeries and Hospitalizations** \_\_\_\_\_

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**Types of Anesthesia Received** ( ) General ( ) Epidural ( ) Regional / Block ( ) Local

<b>Have you had the following?</b>	<b>No</b>	<b>Yes</b>	<b>Have you had the following?</b>	<b>No</b>	<b>Yes</b>
Pneumonia			Hepatitis		
Cough/cold (presently)			Jaundice		
Bronchitis			Kidney infection / stones		
Asthma			Kidney failure		
Emphysema			Brain disease		
Positive TB test			Nerve disease		
High blood pressure			Epilepsy		
Heart murmur			Stroke		
Rheumatic Fever			Diabetes		
Skipped heart beats			Thyroid disease		
Chest Pain			Emotional problems		
Hardening of the arteries			Glaucoma		
Heart failure			Wear contacts		
Heart attack			Bridges, crowns, dentures		
Sickle cell trait or disease			Loose teeth		
Abnormal blood clotting			Bad reaction to anesthesia		
Do you bruise easily?			Cancer		
Do you take a blood thinner?			Hives, eczema, rash		
Do you take steroids or cortisone?			Large scars or keloids		
Are you pregnant? LMP			Slow or poor wound healing		
Do you use tobacco products?			Do you drink alcoholic drinks?		
Type			How much/often		
How much?					

Completed by \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

## Authorization for Release of Information to Family and/or Friends

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Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

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Center for Digestive Diseases and Cary Endoscopy Center, PC, is authorized to release protected health information about the above named patient to the entities named below.

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**Entity to Receive Information. Initial each that is subject to this authorization,**

\_\_\_\_\_ Leave information on the voice mail

\_\_\_\_\_ Give information to spouse

\_\_\_\_\_ Release Financial Information

\_\_\_\_\_ Give information to the following person/s; \_\_\_\_\_

\_\_\_\_\_

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**Rights of the Patient**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Center for Digestive Diseases and Cary Endoscopy, PC. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or State law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Personal Representative

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Description of Personal Representative's Authority (attach necessary documentation)

**CENTER FOR DIGESTIVE DISEASES  
& CARY ENDOSCOPY CENTER  
1120 SE CARY PARKWAY STE 204  
CARY, NC 27511  
PHONE (919) 854-0041  
FAX (919) 854-0049**

**THIS IS VERY IMPORTANT! PATIENTS PLEASE MAKE SURE THAT YOU READ  
AND UNDERSTAND BEFORE SIGNING!**

Dear Patient,

We would like to take this opportunity to acquaint you with our office and billing procedures. It is our goal to satisfy you and make the financial aspects of your health care as convenient as possible. Therefore, as a courtesy to you, we file most insurance.

We will need a photocopy of your insurance card in order to process your claim. Without your card you will be responsible for full payment at the time that services are rendered. If your plan requires an annual deductible, we will need you to bring an explanation of benefits statement/form from your insurance carrier that shows that the deductible has been met.

All patients who have insurance that requires an authorization (referral) are responsible for obtaining that authorization. When no authorization has been received prior to your appointment; you will be asked to either reschedule your appointment or be responsible for the full bill.

**Co pay or coinsurance will be due at the time services are rendered.** If you have a co pay or coinsurance you will be expected to pay it at every office visit. If you are scheduled for a procedure we will be responsible for obtaining authorization if it is needed. We will call your insurance company prior to your procedure to find out approximately what you will owe. We will inform you of what this amount is as soon as we can and **you will be expected to pay it on the day of your procedure.** If this amount includes a deductible and you believe that you have already met it, you will need to bring an explanation of benefits statement/form from your insurance carrier that shows that the deductible has been met.

We require that you notify us twenty-four (24) hours in advance prior to any office cancellations, or forty-eight (48) hours in advance for a procedure cancellation or there will be a \$25.00 charge applied to the patient for the missed appointment and a \$50.00 charge for a missed procedure. The Physicians do reserve the right to cancel an appointment or procedure due to a conflict in scheduling.

We thank you for the opportunity to serve you!

**I have read, understand and accept the above billing and insurance procedures**

\_\_\_\_\_  
Patients Name

\_\_\_\_\_  
Date

# CENTER FOR DIGESTIVE DISEASES and CARY ENDOSCOPY CENTER, P.C.

Due to State of North Carolina Certification Guidelines, we are now required to report, ***Ethnic Origin and Race*** of all patients.

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

**Please Select the appropriate category:**

**Ethnic Origin:**

\_\_\_\_\_ Hispanic

\_\_\_\_\_ Non Hispanic

\_\_\_\_\_ Declined

**Race:**

\_\_\_\_\_ American Indian/ Alaska Native

\_\_\_\_\_ Asian

\_\_\_\_\_ Black/ African American

\_\_\_\_\_ Hispanic

\_\_\_\_\_ Multiple Race/ Other

\_\_\_\_\_ Native American

\_\_\_\_\_ Native Hawaiian

\_\_\_\_\_ Other Pacific Island

\_\_\_\_\_ White

\_\_\_\_\_ Declined/ Unavailable