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______________
Martial 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 outstanding 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.

Date Completed ____________________

PAST MEDICAL HISTORY – PLEASE LIST AND EXPLAIN

SURGERIES:

HEALTH PROBLEMS:

MEDICAL:

MEDICATIONS:

MEDICATION ALLERGIES:

SOCIAL HISTORY:

SMOKING:

ALCOLHOL:

FAMILY HISTORY:

MOTHER:

FATHER:

Date Completed ____________________

Review of Symptoms:

<u>**General:**</u>

	Yes	No
1. Weight Change	☐	☐
2. Fever/chills/night sweats	☐	☐
3. Fatigue/lack of energy	☐	☐
4. Other:		

<u>**HEENT:**</u>

	Yes	No
1. Headaches	☐	☐
2. Sinusitis	☐	☐
3. Visual Disturbances	☐	☐
4. Sore throat/hoarseness	☐	☐
5. Other:		

<u>**Cardio respiratory:**</u>

	Yes	No
1. Chest Pain	☐	☐
2. Dizziness	☐	☐
3. Shortness of Breath	☐	☐
4. Cough/wheezing	☐	☐
5. Peripheral edema	☐	☐
6. Claudication	☐	☐

<u>**Gastrointestinal:**</u>

	Yes	No
1. **Abdominal Pain**	☐	☐
a. Location:		
b. Onset:		
c. Duration/Frequency/Time of day:		
d. Quality:		
e. Related to:		
f. Relived by:		
2. **Upper Symptoms**		
a. Nausea	☐	☐
b. Vomiting	☐	☐
c. Loss of Appetite	☐	☐
d. Gas/Bloating	☐	☐
e. Heartburn	☐	☐
f. Choking		
Solids	☐	☐
Liquids	☐	☐
Intermittent	☐	☐
Constant	☐	☐
3. **Lower GI Tract**		
a. Change in Bowel Pattern	☐	☐
b. Constipation	☐	☐
Laxatives:		
Enemas:		
c. Diarrhea	☐	☐
Frequency:		
Consistency:		
Foul Smelling:	☐	☐

<u>**Genitourinary:**</u>

	Yes	No
1. Urination at night	☐	☐
2. Painful urination	☐	☐
3. Blood in urine	☐	☐
4. Men - Prostate Problems	☐	☐
5. Women - Female Problems	☐	☐
6. LMP	☐	☐

<u>**Rheumatologic:**</u>

	Yes	No
1. Arthralgia	☐	☐
2. Pain or stiffness in neck	☐	☐
3. Muscle weakness	☐	☐
4. Backaches	☐	☐

<u>**Neurologic:**</u>

	Yes	No
1. Problems w/ equilibrium	☐	☐
2. Memory Loss	☐	☐
3. Extremities		
a. Tingling	☐	☐
b. Burning	☐	☐
c. Weakness	☐	☐

____

Patient Name

Authorization for Release of Information to Family and/or Friends

Name of Patient________________________Date of Birth___________________

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.

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;_____________________________
____

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

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 you 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 you 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 pays 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