Carolina Digestive Health Associates

Welcome from Carolina Digestive Health Associates, P.A.

Our goal is to provide you with the utmost professional experience while fulfilling all of your healthcare requirements. We would appreciate your assistance with our registration process.

Please read this letter carefully and complete all included forms before your arrival for the office appointment. Do not mail your forms. Bring them with you.

- This appointment is for an office visit only.
- Please visit our website for practice information and specific office directions at **www.carolinadigestive.com**.
- You will receive an automated appointment reminder call 48 to 72 hours before your appointment. Please follow the prompts to confirm or cancel your appointment.
- If you are unable to attend your appointment, we expect a minimum of 48 hours notice. (Please extend this courtesy as other patients may need these time slots)
- *We charge a $25.00 fee to patients that do not arrive for their appointment or do not provide adequate notice. There is also a $100.00 fee for failure to show for a procedure or fail to provide adequate notice.*
- Please arrive 30 minutes early for your first appointment to allow for timely registration.
- Please bring your insurance card, Photo ID, all current medications (including bottles and creams) and be prepared to pay your co-pay for every visit.
- If you do not have an adult that may accompany you as a translator**,** please provide us 72-hour notice so that we may arrange one for you.
- If your insurance plan requires that you have a referral to see a specialist, we urge you to contact your PCP to confirm that one has been provided for you.
- All nursing home and assisted living residents should be accompanied by someone capable of caring for his or her needs throughout the office visit. Should a resident be dropped off at our facility without appropriate personnel for this level of care, the resident will be sent back to their facility and rescheduled to a later time and day.

Carolina Digestive Health Associates, PA

Patient Registration Form

Patient Information

PATIENT NAME (FIRST, MIDDLE, LAST) ☐ MALE ☐ FEMALE	DATE OF BIRTH AGE	SOCIAL SECURITY NUMBER
ADDRESS	PRIMARY PHONE ☐HOME ☐CELL	ALTNERNATE PHONE ☐HOME ☐CELL
CITY, STATE, ZIP	MARITAL STATUS ☐ SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED	RACE LANGUAGE
EMAIL ADDRESS	EMPLOYER NAME	
EMERGENCY CONTACT NAME/ADDRESS	RELATIONSHIP TO PATIENT	CONTACT PHONE
PRIMARY CARE DOCTOR NAME / ADDRESS		PRIMARY CARE DOCTOR PHONE
HOW WERE YOU REFERRED TO OUR OFFICE? ☐ PHYSICIAN REFERRAL – NAME _____ ☐ MEDIA (PHONE BOOK, ADVERTISEMENT, ETC)	☐ WEBSITE ☐ FRIEND/FAMILY	☐ OTHER: _____

Responsible Party (if other than patient)

RESPONSIBLE PARTY NAME (FIRST, MIDDLE, LAST) ☐ MALE ☐ FEMALE	DATE OF BIRTH AGE	SOCIAL SECURITY NUMBER
ADDRESS	PRIMARY PHONE ☐HOME ☐CELL	ALTNERNATE PHONE ☐HOME ☐CELL
CITY, STATE, ZIP	MARITAL STATUS ☐ SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED	RELATIONSHIP TO PATIENT
EMAIL ADDRESS	EMPLOYER NAME	

Insurance

☐ No Insurance

PRIMARY INSURANCE	PRIMARY INSURED'S NAME	PRIMARY INSURED'S DATE OF BIRTH
SECONDARY INSURANCE	SECONDARY INSURED'S NAME	SECONDARY INSURED'S DATE OF BIRTH

Pharmacy

PHARMACY NAME	PHARMACY LOCATION	PHARMACY PHONE

Disclosure of Information

In the event that I am unable to be reached, I authorize Carolina Digestive Health Associates to communicate personal health details, treatment, or billing information using the following alternative method of communication:

I authorize you to leave a detailed message at the following phone number: _____

I authorize you to send email to me at the following address: _____

I authorize you to disclose detailed health information to the following person(s):

Contact Name: _____ Phone: _____

Contact Name: _____ Phone: _____

I authorize Carolina Digestive Health Associates, PA to treat me at each visit and suggest further treatments as they deem necessary. I authorize release of medical information necessary to my insurance company for payment of claims and assign benefits to Carolina Digestive Health Associates, PA. I understand that I am financially responsible for charges not covered by my insurance carrier, including any collection and/or attorney fees resulting from non-payment of any unpaid outstanding balances.

_____ _____

Patient/Guardian Signature Date

Carolina Digestive Health Associates

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other: _____ _____

Prepared By _____

Signature _____

Date _____

CAROLINA DIGESTIVE HEALTH ASSOCIATES, PA
REQUEST FOR RELEASE OF MEDICAL INFORMATION

To: _____
(Facility Name) *(Address or Fax Number)*

Patient Name: _____ DOB: _____

I authorize you to disclose the following information from the medical record of the above named patient to Carolina Digestive Health Associates at the address or fax number listed below. The purpose of this disclosure is to provide further medical treatment to the patient.

Specific information to be disclosed (please check appropriate items): _____All Records _____Office Visit Notes

_____Operative Reports ____Test Results (Labs, X-rays, Etc.)_____Pathology Reports

Date(s) of Service to be disclosed: From_____to _____

This authorization will expire on the following date: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

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

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in the document. I can do this by written notification to Carolina Digestive Health Associates, PA at one of the addresses listed below.

_____ _____ _____
(Signature of Patient or Representative) *(Date)* *(Relationship to Patient)*

Please send records via_____Fax_____Mail to the attention of Dr._____at the Carolina Digestive Health Associates office checked below:

☐ 300 Billingsley Rd, Suite 200
Charlotte, NC 28211
704-372-7974 (Office)
704-372-4966 (Fax)

☐ 10620 Park Rd, Suite 102
Charlotte, NC 28210
704-543-7305 (Office)
704-543-6392 (Fax)

☐ 1450 Matthews Township Pkwy, Suite 460
Matthews, NC 28105
704-814-0779 (Office)
704-814-0789 (Fax)

☐ 1663 Campus Park Dr., Suite D
Monroe, NC 28112
704-291-2488 (Office)
704-291-7533 (Fax)

☐ 1223 Spruce Street
Belmont, NC 28012
704-820-9430 (Office)
704-820-9426 (Fax)

☐ 8220 University Executive Park Drive, Ste.125
Charlotte, NC 28262
704-547-8818 (Office)
704-414-0023 (Fax)

☐ 705 Griffith St. Ste.205
Davidson, NC 28036
704-799-2750 (Office)
704-799-2760 (Fax)

☐ 1085 NE Gateway Court Suite 280
Concord, NC 28025
704-455-9700 (Office)
704-455-6677 (Fax)

CAROLINA DIGESTIVE HEALTH ASSOCIATES, PA

Patient Financial Responsibility Agreement

In order for Carolina Digestive Health Associates, P.A. to continue providing our patients with quality medical care, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our PATIENTS' RESPONSIBILITY.

As a patient of Carolina Digestive Health Associates, P.A., you are hereby agreeing:

- To pay all non-insured charges, including your co-pay, co-insurance, insurance deductible, out-of-network charge differential, and all other non-covered charges at the time of service or when otherwise advised.

- To provide us with a copy of your current insurance card or other Proof of insurance at the time of EACH service, including hospital-based services. If you do not provide us with valid insurance information at the time of EACH service, you agree to personally pay all unpaid charges.

- To obtain any required authorization under your insurance plan for our services from your primary care physician and/or your insurer prior to each appointment. If you do not receive the required authorization, your insurer may not pay us for our services. In these cases, you agree to personally pay any resulting unpaid charges.

- To monitor your insurance company's payment of your account and, if unpaid within 60 days from the date of service, to contact them regarding non-payment and to cooperate with CDHA to resolve the unpaid status of your account.

- We charge a $25.00 fee to patients that do not arrive for their appointment or do not provide adequate notice.

Further, you agree that your physician and Carolina Digestive Health Associates, P.A. has the right to be paid for their services and you acknowledge:

- **That unpaid bills older than 60 days from date of service may be turned over to a debt collection agency or attorney for collection.**

- **That you will be responsible for any resulting collection fees, including reasonable attorney fees, and/or bank fees incurred as a result of a returned check.**

By my signature, I am indicating that I have read, understand and agree to the above provisions.

_____ _____

Patient or Guarantor Signature **Date**

Patient Interview Form Consent

Patient Name: _____

Patient DOB: _____ Patient MRN: _____

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

☐ Yes ☐ No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

☐ Yes ☐ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

☐ Yes ☐ No

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

_____

Signature Date

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

Sex

☐ Male ☐ Female ☐ Other

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race

Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Unknown ☐ Patient declines to specify

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Vietnamese ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Cell phone ☐ Telephone call - Home ☐ Patient declines to specify

Other:_____

Pharmacy

_____

Name Address Phone

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Latex	☐ Penicillins	☐ aspirin	☐ Iodine-Iodine Containing	☐ Sulfa (Sulfonamide Antibiotics)
☐ Codeine Sulfate	Other:	Other:	Other:	Other:

Current Medications

☐ None

Name	Dose	How taken?

Past or Present Medical Conditions

- [ ] None

- [ ] Arthritis
- [ ] Artificial Heart Valve
- [ ] Alzheimer's Disease
- [ ] Anemia
- [ ] Asthma / Bronchitis
- [ ] Bleeding problems
- [ ] Colon cancer
- [ ] COPD / Emphysema
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diabetes
- [ ] Fibrositis / Fibromyalgia
- [ ] Gallstones
- [ ] Glaucoma
- [ ] Heart disease
- [ ] Heart Murmurs
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High blood pressure
- [ ] Colon polyp history
- [ ] HIV
- [ ] Irritable Bowel Syndrome
- [ ] Kidney disease
- [ ] Parkinson's Disease
- [ ] Reflux Disease (GERD)
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Ulcer Disease
- [ ] Stroke
- [ ] Thyroid disease
- [ ] Tuberculosis
- [ ] Ulcerative Colitis
- [ ] Defibrillator

Other: _____ Other: _____ Other: _____

Previous Procedures

- [ ] None

- [ ] Defibrillator Placement
- [ ] Pacemaker Insertion

Other: _____

When: _____ When: _____

Immunizations

- [ ] None

- [ ] Influenza, seasonal, injectable
- [ ] Pneumonia vaccine

Other: _____

When: _____ When: _____

Diagnostic Studies/Tests

- [ ] None

- [ ] Abdominal Ultrasound
- [ ] EGD
- [ ] Colonoscopy
- [ ] Flexible Sigmoidoscopy
- [ ] CT Abdomen

When: _____ When: _____ When: _____ When: _____

- [ ] Mammography; bilateral

Other: _____

When: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown
- [ ] Other

Alcohol

- [ ] None

	Type	Quantity	Number	Frequency
[ ]	spirits			

Caffeine

- ☐ None
- ☐ caffeine Intake:_____

Tobacco

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency

Drug Use

- ☐ None

	Type	Quantity	Number	Frequency
☐	Marijuana			
☐	Cocaine			
☐	IV Drugs			

Family Medical History

- ☐ No knowledge of family history

No family history of

- ☐ Celiac sprue
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Liver disease
- ☐ Ulcerative Colitis / IBD

Health Status	Father	Mother	Brother	Sister
Deceased/At Age	○____	○____	○____	○____
Cause of Death	_____	_____	_____	_____
Diagnoses				
History of colon cancer	○	○	○	○
History of colon polyps	○	○	○	○
Crohn's disease, colon	○	○	○	○
Diabetes mellitus (Type I)	○	○	○	○
Diabetes mellitus (Type II)	○	○	○	○
Gallstones	○	○	○	○
Pancreatitis	○	○	○	○
Ulcer, gastric	○	○	○	○
Ulcerative colitis	○	○	○	○
Other:	○	○	○	○
Other:	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
irregular heart beat	○	○
Shortness of Breath	○	○
Swelling of Ankles	○	○
Pacemaker	○	○
Defibrillator	○	○
Stents	○	○

Constitutional

None	Y	N
Feeling Tired	○	○
fever	○	○
sweats/chills	○	○
weight gain	○	○
weight loss	○	○
Pregnant	○	○
Jaundice	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
nose bleeds	○	○
sore throat	○	○
Hearing Aid	○	○
Hoarseness	○	○
Sinus Problems	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

None	Y	N
Blurred Vision	○	○
Glaucoma	○	○
Contacts or Glasses	○	○

Genitourinary

None	Y	N
frequent urination	○	○
Blood in Urine	○	○
Incontinence	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
heartburn	○	○
nausea	○	○
vomiting	○	○
Anal Itching	○	○
Anal Pain/Sore	○	○
Appetite loss	○	○
Belching	○	○
Bloating	○	○
Difficulty Swallowing	○	○
Get full easily	○	○
Incontinence of Stool	○	○
Pain on Swallowing	○	○
Pain when Defecating	○	○
Black / Tarry Stool	○	○
Maroon Stool	○	○
Rectal Bleeding	○	○
Vomiting Blood	○	○
"Coffee Grounds"	○	○
blood in stool	○	○

Hematologic/Lymphatic

None	Y	N
Anemia	○	○
easy bleeding/bruising	○	○
past blood transfusion	○	○

Integumentary

None	Y	N
itching	○	○
skin ulcers	○	○
rashes	○	○

Musculoskeletal

None	Y	N
Back pain	○	○
Joint pain	○	○
Muscle Pain	○	○
Joint Replacements	○	○
Joint Swelling	○	○

Neurological

None	Y	N
fainting	○	○
frequent headaches	○	○
seizures	○	○
Brain/Spinal Injury	○	○
Confused	○	○
Weakness/Numbness	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○

Respiratory

None	Y	N
Chronic cough	○	○
Sleep Apnea	○	○
Use of C-PAP	○	○
Difficulty opening Mouth	○	○
Positive TB skin test	○	○
wheezing	○	○
DifficultyTurning head	○	○
Use of Oxygen @ Home	○	○