CAROLINA DIGESTIVE HEALTH ASOCIATES, P.A.

# Patient Instructions for Hospital Scheduled Procedures

Patient Name:_____ Chart # _____

Date of Procedure:_____ Arrival Time: _____

**Please read and initial the following important policies**

_____ 1. Please complete the paperwork in your packet and return in the pre-addressed envelope included in your packet. Please bring identification with your picture on it and your Insurance Card.

_____ 2. Certain patients do not meet the requirements to be scheduled in our Endoscopy Centers. Your procedure will be scheduled in a hospital setting if your body mass index is over 45, if you have an ICD (Implantable Cardioverter Defibrillator), if your overall health is poor or unstable, or if the doctor feels your health care will be better managed in a hospital setting.

_____ 3. A responsible driver MUST accompany you to the Hospital and must stay at the facility for the duration of your procedure and return you to your home when you are discharged. **Your procedure will be canceled if you arrive alone or if the person bringing you cannot stay at the facility for the duration of your procedure.** Plan on being at the hospital approximately 2-2 ½ hours.

_____ 4. If a need is identified, the scheduler will arrange for an interpreter to be present at the hospital for your procedure. This will be at no cost to the patient. If you decline the interpreter, please let the scheduler know.

_____ 5. Please make sure that you have received a copy of your preparation (prep) instructions. If you do not completely understand the prep instructions, please call our office and speak to a scheduler for clarification.

_____ 6. If you need to cancel your procedure, you must call our office three (3) business days prior to the procedure. If an emergency occurs the morning of the procedure, you must call the hospital. The hospital Endo unit opens between 5:30am and 6:00am. **If you do not show up for your procedure and you have not called our office or the hospital you will be charged a $100.00 No Show fee.**

_____ 7. **Please contact your insurance carrier prior to the procedure. It is your responsibility to verify your benefits and obtain any necessary PCP referral if needed. Our office will check to see if an authorization is required. Please contact the benefits department if you need assistance with this process.**

_____8. Please do not wear jewelry to the hospital and please leave all valuables at home.

_____9. Please do not apply any lotion, skin softeners or perfume, as this interferes with our monitoring equipment.

**I have read and understand the policies above.**

_____

Patient's Signature Date

August 2012

# 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<br>☐ SINGLE ☐MARRIED ☐DIVORCED<br>☐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 _____ ☐ WEBSITE ☐ OTHER: _____

☐ MEDIA (PHONE BOOK, ADVERTISEMENT, ETC) ☐ FRIEND/FAMILY

## 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<br>☐ SINGLE ☐MARRIED ☐DIVORCED<br>☐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 fee to patients that do not arrive for their appointment or do not provide adequate notice.
  $25.00 Physician Visit

**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**

# Checking Your Healthcare Insurance Benefits

After scheduling any procedure, we recommend you call your insurance carrier to verify your benefits. **It is your responsibility to determine what your benefits cover.** Please know that Carolina Digestive Health will provide your insurance carrier with all necessary information for your policy to cover the procedure at the maximum allowed amount.

| Procedure | CPT Codes |
|---|---|
| Colonoscopy (outpatient) | 45378-45386 – with and without findings Colonoscopy (in office |
| BCBS of NC @ Billingsley) | 45378-45386 – with and without findings |
| EGD (outpatient) | 43235-43259 |
| EGD (in office BCBS of NC @ Billingsley) | 43235-43259 |
| Flex Sig (outpatient) | 45330-45345 |
| Flex Sig (in office BCBS of NC @ Billingsley) | 45330-45345 |
| _____ | Hospital Procedure (outpatient) |

- Screening Colonoscopy: Preventative/Wellness (absence of symptoms and/or history)
- Diagnostic Colonoscopy: Symptoms and/or History exist requiring the procedure

**If your doctor finds a polyp or other findings during the procedure, your insurance carrier may no longer consider this a preventative/wellness screening procedure. It may then be considered a diagnostic procedure and your insurance benefits may change. Please verify your benefit for both when calling your insurance company.**

**You will incur up to 4 separate statements for your procedure: (1)** the physician's charge **(2)** the facility charge from the ambulatory surgery center **(3)** pathology (if any polyps/biopsies are removed) **(4)** anesthesia.

**On the day of you procedure, you will be given anesthesia.**

You will receive a phone call from CDHA regarding your benefits 1 week prior to your procedure, if you owe anything at the time of the procedure. If you do not receive a call you may contact the benefits department at 704-218-3169.
****Please keep in mind you will not receive a phone call if you do not owe anything at the time of the procedure.**

If you received a bill from one of the outside vendors below, please contact them directly regarding billing questions, as we are not the providers of those services.

| Carolina Endoscopy Centers | Anesthesia | Pathology |
|---|---|---|
| Billingsley | Carolina Digestive | Carolina Digestive |
| | 704-372-7974 | 704-372-7974 |
| Pineville | Carolina Anesthesia | Carolina Pathology |
| | 800-951-7850 | 704-973-5500 |
| Monroe | Carolina Anesthesia | Celigent Diagnostic |
| | 800-951-7850 | 704-973-5500 |
| University/Huntersville | American Anesthesiology | Carolina Pathology |
| | 888-280-9533 | 704-973-5500 |

***Patient MRN:*** _____

***Please initial the following line, stating we provided you with the above information:*** _____

Patient Name: _____

Patient MRN: _____

Patient DOB: _____

## 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 spirits

Quantity _____ Number _____ Frequency _____

**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 | ○ | ○ |