



Carolina Digestive Diseases & ENDOSCOPY CENTER

*****Please complete & bring to your appointment,
along with all Insurance cards, photo ID and your current medications
(either pill bottles or a current list)*****

Name _____ Today's Date _____

DOB _____ SSN _____

Address _____ Home # _____

City _____ Work # _____

County _____ State _____ Zip _____ Cell # _____

Email Address _____ **May we contact you by email?** Yes No

Race _____ Ethnicity: (*circle one*) Hispanic Non-Hispanic

Male or Female (*circle one*) Marital Status: M S D W

Emergency contact _____ Emergency phone# _____

Emergency contact's relation _____

Primary Care Physician _____

Referring MD for today's visit _____

Pharmacy _____ **Pharmacy Location** _____

Insurance Information

Primary Insurance	Secondary Insurance
Insured By: Self / Spouse / Parent	Insured By: Self / Spouse / Parent
Insurance Name:	Insurance Name:

Patient Signature _____ Date _____



Practice Policies

To ensure a pleasant and efficient relationship between CAROLINA DIGESTIVE DISEASES and YOU, we urge you to read our clinic policy carefully and sign at the bottom. A copy will be provided to you upon request.

GENERAL POLICY

1. Be prepared to pay a Co-Pay or payment at time of visit. You must present your insurance card at EACH visit!
2. As a patient of our office, you authorize the use and disclosure of your health information for the purposes of treatment, payment and healthcare operations. You also give consent for the healthcare providers of Carolina Digestive Diseases, PA to evaluate and render medical treatment.
3. By consenting to being seen in our office, you authorize your insurance benefits to be made payable directly to Carolina Digestive Diseases, PA, realizing that you are responsible for payment of any non-covered service

APPOINTMENT POLICY

1. Patients with scheduled appointments will be seen in order of appointment times.
2. A 24-hr Cancellation Notice is required for all appointments, otherwise a \$75 cancellation fee will be billed to you.
3. For "No-Show" appointments, a \$75 fee will be billed to you.
4. Patients arriving 15 minutes or more late for their appointment may either wait to be worked back into the schedule or may reschedule to a different date.

PRESCRIPTION REFILL POLICY

1. Please allow 48 hours for a prescription refill to be authorized. Therefore, please do not let your medicine run out before requesting a refill. After 48 hours, please check with your pharmacy to verify the RX has been called in.
2. To expedite your request, please contact your pharmacy, who in turn will send us an electronic request for your refill. Please be advised that compliance with your recommended medical treatment is required to continue to receive medication refills.
3. Refill requests received after 4:00 PM are handled on the next business day.

TELEPHONE MESSAGE and PATIENT PORTAL POLICY

1. Please allow 48 hours for the nurse to return any non-urgent telephone messages or portal messages.
2. To facilitate a prompt response, please state/explain the reason for your call/message.
3. For any life threatening emergency or urgent matter, please call 911. DO NOT use the portal for emergent needs!!

MEDICAL LEAVE/DISABILITY FORMS

Carolina Digestive Diseases, PA charges \$20.00 for any forms requested to be filled out for any medical leave or for disability requests. Forms dropped off will not be completed until fee is paid. This fee must be paid in cash only, no credit/debit card payments.

RETURNED CHECK POLICY

Fee \$35.00

PRIVACY POLICY

Carolina Digestive Diseases, PA adheres to HIPAA and protection of all patient information. Your signature below indicates that you have received a copy of our Notice of Privacy Practices and HIPAA Policy.

PATIENT RIGHTS & RESPONSIBILITIES

Your signature below indicates that you have been given information on our policy of Patient Rights & Responsibilities.

I have read and understand the above policies and agree to abide by their terms.

Name of Patient: _____ **Date:** _____



Date _____ Patient Name _____ DOB _____

Family/Social History

Have you ever had a blood transfusion? Y or N
 If yes, Date _____ and # Units _____

Do you smoke? Y or N If quit, date _____
 ___ # packs per day for ___ years

Do you drink alcohol?(circle) Beer Wine Liquor
 How many drinks per week? _____

Do you or have you used illegal drugs? Y or N

Do you have children? Y or N ___ how many?

Occupation _____

Who do you live with? _____

Father's age _____ or age at death _____

Cause of death _____

Health Problems _____

Mother's age _____ or age at death _____

Cause of death _____

Health Problems _____

Brothers/Sisters Age Health Problems Age at Death

Procedures/Surgical History

Type of Surgery/Procedure Date

Allergies:

Medications

Please list all medications you are currently taking,
 including over the counter and herbal remedies.

Medication

Dose/Frequency



Carolina Digestive Diseases & ENDOSCOPY CENTER

Date: _____ Pt Name _____ DOB: _____

Past Medical History

Please circle if you have been diagnosed with any of the following:

- | | | | |
|------------------------------------|-----------------------------------|---|-------------------|
| Colon Cancer | Artificial/Mechanical Heart Valve | † | Stroke |
| Throat/Stomach Cancer | Joint Replacement | | High Cholesterol |
| Liver/Pancreatic Cancer | Hepatitis | | Emphysema |
| Breast Cancer | Kidney Stones | † | Pneumonia |
| Lung Cancer | Blood Clots | | Osteoporosis |
| Cancer-Other | Sexually Transmitted Diseases | | Lupus |
| HIV/AIDS | Asthma | † | Liver Disease |
| Crohn's/Ulcerative Colitis | Diabetes | | Bleeding Problems |
| Blood Transfusions | Thyroid Diseases | † | Tuberculosis |
| High Blood Pressure | Psychiatric Problems | | |
| Heart Problems/Irregular Heartbeat | | | |

Review of Systems

Please circle or fill in any of the symptoms below which you have experienced within the past 3 months:

- Allergic/ Immunologic: **No Problem** or HIV exposure, persistent infections, strong allergic reactions or urticaria
Other _____
- Cardio-Vascular: **No Problem** or Chest pain, irregular heartbeat, leg swelling, orthopnea, palpitations, syncope
Other _____
- Constitutional: **No Problem** or Weight gain, weight loss, fever, weakness, fatigue, headaches, loss of appetite, sweats
Other _____
- Ears/Nose/Mouth/Throat: **No Problem** or Hoarseness, difficulty swallowing, sinus problems, dizziness, ear pain, sore throat
Other _____
- Endocrine: **No Problem** or Excessive thirst, hair loss, heat intolerance
Other _____
- Eyes: **No Problem** or Blurred vision, double vision
Other _____
- Gastro-Intestinal: **No Problem** or Abdominal pain, abdominal swelling, change in bowel habits, colon polyps, constipation, diarrhea, gas, gastric polyps, h pylori, heartburn, hemorrhoids, hiatal hernia, nausea, rectal bleeding, stomach cramps, ulcers, vomiting
Other _____
- Genitourinary: **No Problem** or Dark urine, dysuria, decreased urine flow, frequent UTI's, hematuria, impotence, difficulty urinating
Other _____
- Hematological/Lymphatic: **No Problem** or Swollen lymph nodes, easily bruises, prolonged bleeding, anemia, bleeding gums
Other _____
- Skin: **No Problem** or Allergies, dryness, itching, jaundice, rashes
Other _____
- Musculo-Skeletal: **No Problem** or Arthritis, back pain, gout, joint deformity, joint pain
Other _____
- Neurological: **No Problem** or Fainting, headaches, migraines, numbness or tingling, seizures, tremors, vertigo
Other _____
- Psychiatric: **No Problem** or Anxiety, depression, difficulty sleeping, hallucinations, nervousness, panic attacks, paranoia
Other _____
- Respiratory: **No Problem** or Asthma, cough, dyspnea, hemoptysis, wheezing
Other _____

We now have an interactive online portal designed specifically for you, our valued patient!

- ➡ To Register:
1. You will receive an invitation email from our practice with a link and unique ID that will take you through the registration process.
 2. Click on the link in the invitation email to create a unique user ID and password.
 3. Once registered, complete your medical, family and social history.
 4. Click send to submit your information directly to our office.

- ➡ How To:
- Send a message to my Doctor's office?**
- Click on the message tab.
 - Click "new" and compose your message.
 - Remember to hit send.
- Receive messages through Patient Portal?**
- You will receive a notification email when you have a message waiting in Patient Portal.
 - Click on the message tab.
 - Click on "new messages" to view your messages.
- Update my personal information?**
- Click on Health Summary, then click on update.
 - Change the information you want.
 - Click on "send" to submit changes.
- Reset my Password?**
- Click on My account/change password.
 - Enter username, DOB and registered email address.

- ➡ Questions:
- Q** Can I schedule my appointment online through Patient Portal?
A You may send a request to schedule your appointment and our practice will contact you.
- Q** Does Patient Portal allow me to send a message directly to my physician's office?
A Yes, you may send a message directly to our office through Patient Portal. We will make sure your message reaches the correct person to answer your question
- Q** Can I refill my prescription through Patient Portal?
A No, you must go directly through your pharmacy in order to refill your prescription
- Q** What do I do if my account is locked due to too many failed log-in attempts?
A Click on the "change password" tab and follow the instructions to create a new password

- Benefits:**
- | | |
|--------------------------------------|--------------------|
| With the portal, you can.... | |
| Request appointments | Check your results |
| Send a message to our practice | Log-on 24/7 access |
| Update your personal medical records | |

- Start:**
- Take an active role in your healthcare!
 - Create your username and password today.
 - Recommended for Internet Explorer 8 or higher or Mozilla Firefox

Carolina Digestive Diseases Endoscopy Center
Your Rights and Responsibilities as Our Patient

This center is a physician owned facility. You may exercise the following rights without being subjected to discrimination or reprisal.

Patient Rights – You have a right to:

- Considerate, respectful, and safe care *that is free from abuse or harassment.*
- A discussion of your illness, what we can do about it, and the likely outcome of care.
- Know the names and roles of the people caring for you here.
- Respectful and effective pain management.
- Receive as much information to consent to or refuse a course of treatment or invasive procedure and to actively participate in decisions regarding your medical care.
- Involve your health care proxy or significant others in the decision making process for medical decisions.
- Reasonable continuity of care and to know in advance the time and location of an appointment as well as the doctor you are seeing.
- Full consideration of personal privacy and confidentiality of your medical information. Your written permission will be obtained prior to releasing any medical information. When we do release your information to others, we ask them to keep them confidential.
- Review your medical record and ask questions unless restricted by law.
- Know of any relationships with other parties that may influence your care.
- Know about rules that affect your care and about charges and payment methods. You have a right to receive and examine an explanation of your bill regardless of the source of payment.
- Receive assistance with the transfer of care from one provider to another within our practice or to an external provider not in our practice.
- You have a right to develop a living will or healthcare power of attorney although, since the procedures we do are not high risk, we will do all that is necessary to stabilize you including CPR if an emergency occurs. EMS will be called and you will be transferred to the hospital.
- Voice your concerns, complaints, or problems with the care you received by contacting our manager at 252-758-8181. If we are unable to satisfactorily address your complaint, you may contact the NC Medical Board at 1-800-253-9653 or AAAHC 1-847-853-6060 or www.aaahc.org.

Patient Responsibilities – You agree to:

- Provide accurate and complete information concerning your symptoms, past history, current health status, and medications including over-the-counter products and dietary supplements.
- Make known whether you clearly comprehend your medical care and what is expected of you in the plan of care.
- *Participate in the development of the treatment plan and follow care instructions given to you.*
- Follow the treatment plan and care instructions given to you.
- Keep appointments and notify us if you are unable to do so.
- Accept responsibility for your actions if you refuse planned treatment or do not follow your doctor's orders.
- Accept financial responsibility for care received and pay promptly.
- Follow facility policies and procedures.
- Inform my doctor about any living will, medical healthcare power of attorney, or other directive that may affect my medical care.
- Be respectful of all healthcare providers and staff as well as other patients.
- Inform the staff of any discomfort or pain and patient safety issues.
- Share your values, beliefs, and traditions to help the staff provide appropriate care.
- *Provide a responsible adult to transport you home and remain with you if you receive sedation medications.*

Additional Information for Medicare Patients

All issues, concerns, or complaints can be reported by contacting our Office Manager or Nurse Manager. If we are unable to address your concerns, you may contact the following for assistance.

- Medicare Ombudsman www.medicare.gov/ombudsman/resources.asp
- NC DHSR Complaint Intake Unit www.dhhs.state.nc.us/dhsr/ciu/complaintintake
Rita Horton, 2711 Mail Service Center, Raleigh, NC 27699 or 1-800-624-3004 or 1-919-855-4500

Advance Directives – Living Will or Health Care Power of Attorney Resources

For applicable state laws and sample forms for creating a living will or healthcare power of attorney, you may contact one of the following.

- Caring Information Organization at 1-800-658-8886 for English or 1-877-658-8896 for other languages or www.caringinfo.org
- NC DHHS Division of Aging and Adult Services at 1-800-662-8859 or www.ncdhhs.gov/aging/direct
- Carolinas End of Life Care at 1-919-807-2162 or www.carolinasendoflifecare.org

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