CarolinaDigestiveDiseases
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*****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 _____

Consent to Release Medical Information to Family

Do you consent/request to have your medical information released to anyone other than yourself?

□ **No** □ **Yes** **Pt signature** _____ **Date** _____

If yes, please list names and relationship of who you authorize us to speak to regarding your health information:

Name _____ Relationship _____

Name _____ Relationship _____

Insurance Information

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

Patient Signature _____ Date _____

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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 courtesy, our staff will verify and bill your insurance, but we cannot guarantee coverage or that the information we have received from your carrier and conveyed to you is accurate or complete. You should verify and be familiar with your insurance benefits prior to your appointment.
3. 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.
4. 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
5. Collection balances must be paid to receive refills, appointments or procedures.

APPOINTMENT POLICY

1. Patients with scheduled appointments will be seen in order of appointment times, not arrival times.
2. A fee is applied for any cancellations, reschedules or no shows made **within 48 business hours** of appointment time. **Office visits: 1st occurrence $75 fee, 2nd occurrence $150 fee, 3rd occurrence $200 and/or discharged from practice. Procedures: 1st occurrence $150 fee, 2nd occurrence $300 fee, 3rd occurrence-discharged from practice.** Appointments rescheduled inside a 48-hour window will not be placed back on schedule for 2 weeks. Patients who no-show will not be place back on the schedule for 3 months.
3. Patients arriving 15 minutes or more late for their appointment may either wait to be worked back into the schedule or will be required to 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. We do NOT provide refills over the weekend!

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 checks or 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: _____

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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

_____
_____
_____
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_____
_____
_____
_____
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_____

Allergies:

_____
_____
_____

Medications

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

Medication Dose/Frequency

_____
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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_____

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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
Send a message to our practice
Update your personal medical records
Check your results
Log-on 24/7 access

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

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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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