California Digestive Care
Gastroenterology & Advanced Endoscopy
Rishi Sharma M.D. - Cynthia Mullen M.D.
A Division of BASS Medical Group

Dear New Patient:

Welcome, and thank you for choosing us!

The enclosed packet contains important information for your upcoming appointment as well as our new patient registration forms. To be prepared for your appointment, please review this information carefully and bring the requested information with you on the day of your appointment.

It is very important to bring the following to your first visit:

√ Completed Patient Information Forms, Patient History Forms & Signed Notice of Privacy Practices (enclosed in this packet)

√ Insurance Card(s) and Insurance Referral, if applicable

√ Picture Identification (such as a driver's license)

√ A list of your current medications with dosage and frequency taken

√ Any recent Laboratory (blood work) results related to your visit with us

√ Any recent Radiology results related to your visit with us (e.g., Upper GI Testing, Barium Enema, CT scan or Ultrasound results)

√ For patients enrolled in HMO plans, a referral may be required from your Primary Care Physician. Please check with your insurance carrier to verify the requirements of your plan √ Co-payment, if applicable. Please note that payment is due at the time of service.

Providing the above information on the day of your appointment will allow us to serve you in the most prompt, accurate and efficient manner.

Thank you for allowing us to participate in your medical care.

We look forward to seeing you soon!

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Patient Demographics

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: _____ Date of Birth: ____/____/_____ Race/Ethnicity: _____

Marital Status: Single Married Divorced Widow (circle one)

Address: _____ City:_____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____@_____ Occupation: _____

Guarantor: _____ Phone: _____ Home Cell Work (circle one)

Emergency Contact: _____ Phone : _____ Home Cell Work (circle one)

Referring Physician: _____ Primary Care Physician: _____

Primary Insurance Coverage

☐ Please check this box and do not complete the following sections if you have provided us with a copy of your insurance card

Carrier: _____ Plan ID/ Name: _____ Effective Date:_____/_____/_____

Group ID/ Name: _____ Member Policy ID #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Relationship to Subscriber: _____ Subscriber Employer: _____

Claims Address: _____ Carrier Phone:_____

Secondary Insurance Coverage

Carrier: _____ Plan ID/ Name: _____ Effective Date:_____/_____/_____

Group ID/ Name: _____ Member Policy ID #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Relationship to Subscriber: _____ Subscriber Employer: _____

Claims Address: _____ Carrier Phone:_____

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PATIENT HISTORY FORM

Patient Name	Date of Birth	Age	Gender	Referring Physician

Primary Reason for Your Visit Today:

□ Colon Cancer Screening □ Other (Please Explain Briefly):

Have you had any of the following illnesses?

___ High blood pressure ___ Arrhythmias ___ Heart Disease ___ Diabetes Mellitus
___ Bleeding disorder ___ Taking Blood Thinners ___ Pacemaker ___ Internal defibrillator (ICD)
___ Heart murmur ___ Heart valve disease ___ Stroke ___ Sleep apnea
___ Cardiac Stent(s) ___ Chronic Kidney disease ___ Asthma
___ Emphysema/Chronic bronchitis

Other Medical Problems: _____
_____

Prior Surgeries: ___ Colon/Bowel Resection ___ Gall Bladder ___ Abdominal Surgery ___ Hysterectomy
___ Hemorrhoid ___ Gastric Bypass/ Banding ___ Fundoplication Other:_____

Medications taken regularly and Dose (including over-the-counter & supplements):

_____
_____

Drug allergies: **___ NO known Drug Allergies**

___ Penicillin ___ Sulfa ___ Latex ___ Iodine Other:_____

Social History: Occupation_____ □ Smoking:___pack(s)/day □ Don't smoke □Marijuana
Alcoholic beverages: □Don't drink □1-5/week □6-10/week □ >10/week □ Drug Use _____
Exercise: ___ # days/week Type of Activity: _____

Any Family History of: ___ Colon Cancer ___ Colon Polyp ___ Crohn's disease/Ulcerative colitis
___Gastrointestinal/Biliary cancers ___ Other cancer(s): _____
___Other Gastrointestinal Diseases: _____

Age(s)	Deceased	List Any Major Health Problems
Mother:	_____	___ _____
Father:	_____	___ _____
Siblings:	_____	___ _____
Children:	_____	___ _____

Others: _____
_____

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Height: _____ Weight: _____

Review of Systems:

General	**Respiratory**	**Head, Eyes, ears, Nose, Throat**
___Weight loss	___Frequent cough	___Headache
___Weight gain	___Bloody sputum	___Ear ache
___Chills	___Wheezing	___Impaired hearing
___Fever		___Sore Throat
Gastrointestinal (Digestive)	**Cardiovascular**	___Throat Clearing
___Poor appetite	___Chest pain	___Glaucoma
___Trouble swallowing	___Shortness of breath	
___Pain with swallowing	___Heart attack	**Hematological**
___Heartburn	___High blood pressure	___Slow to heal after the cuts
___Regurgitation food	___Heart murmur	___Anemia
___Nausea		___Iron deficiency
___Vomiting	**Locomotor/Musculoskeletal**	___Abnormal bruising
___Vomiting blood	___Muscle pain/weakness	___History of excessive bleeding
___History peptic ulcer disease	___Joint pain /swelling	after tooth extraction or surgery
___Bloating	___Back pain	
___Abdominal pain		**Endocrine**
___Gallbladder surgery	**Genitourinary**	___Hormone therapy
___Abdominal surgery	___Urinary burning sensation	___Hot intolerance
___Liver disease	___Blood in urine	___Cold intolerance
___Hepatitis		___Thyroid disease
___Blood transfusion	**Neuro-Psychiatric**	___Diabetes
___Jaundice	___Depression	
___Pancreatic disease	___Anxiety	**Gynecological**
___Diarrhea	___Dizziness	___Vaginal discharge
___Constipation	___Seizures	___ Abnormal vaginal bleeding
___Black colored stool	___Substance Abuse	___ Heavy Menstrual periods
___Diverticulosis		___Menopause
___History of colon polyp/cancer	**Neck**	**Skin**
___Blood in stool	___Stiffness	___Tattoos
___Mucus in stool	___Enlarged glands	___Rash, hives, eczema
___Fecal incontinence		___Abnormal pigmentation
___Anal pain or itching		
___Anal fissure	Other:_____	

Preferred Pharmacy:_____
Name *Address* *Phone*

Patient Name (Printed) of Patient or Representative: _____

Signature of Patient or Representative: _____ Date: _____

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FINANCIAL POLICY ACKNOWLEDGEMENT AND AGREEMENT

In this era of complex and often-confusing billing practices, we are committed to doing our part to help keep healthcare affordable and minimize unexpected expenses. Please read carefully. When you sign below you are acknowledging and agreeing to the following financial policies:

PATIENT COPAYMENTS

All applicable copays are required **at the time of service**. Our practice accepts **credit or debit card** payment only. We are no longer able to accept cash or check payments in the office.

APPOINTMENT NO-SHOW AND LATE CALNCELLATION POLICY

Cancellations less than 3 business days prior to your office visit or less than 5 business days prior to your procedure are subject to a late cancellation/no-show fee: $35 for office appointments and $250 for procedures. This may be billed to your account.

PAYMENTS AND COLLECTIONS

We bill **participating** insurance companies. The patient is financially responsible for any services provided including any balances not covered by insurance. The patient agrees to pay those balances due within 20 days of receipt of a statement. Late payments are subject to a monthly fee on unpaid balances. Balances not paid within 45 days of receipt of a statement are subject to collections. If collections become necessary, the patient will be responsible for any cost incurred. **Any questions regarding billing may be directed to (925) 624-3424**

1. I understand and agree to all financial policies listed above.

2. I authorize disclosure of my personal health information (PHI) to the extent necessary for insurance, billing and treatment purposes.

3. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance and any other insurance plan.

4. I understand I am financially responsible for all charges not paid by said insurance company, including any deductibles, copays and co-insurance, and that copays are due at the time of services.

Patient Name or Representative (Printed): _____

Signature of Patient or Representative: _____ Date: _____

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Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

We are dedicated to maintaining the privacy of your protected health information. Federal and state laws ensure the privacy of your medical records, their availability to you, and specific rights regarding your medical records. In addition to your authorization, we may use or disclose your health information in accordance with the law under certain circumstances. Please refer to our full HIPAA Notice of Privacy Practices for all potential general use and disclosures.

I UNDERSTAND MY RIGHTS TO:

Revoke or change the authorization below at any time. (Please note, revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the notice to revoke). I may also inspect or copy my protected health information to be disclosed as described in this document. I understand that if the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

DISCLOSURE AND RELEASE OF PAPER OR ELECTRONIC RECORDS:

Voicemails:

_____ I **DO NOT** authorize the disclosure or release of my protected health information to any person/entity or via a message left on a **voicemail**.

or

_____ I **DO** authorize the physicians and staff of the practice to disclose health information regarding appointments, labs bills or other general patient communication via **voicemail** on the following telephone numbers:

Telephone #: _____ Telephone #: _____

Disclosure to Others:

_____ I **DO NOT** authorize disclosing or releasing information about my care to ANY family or friends

or

_____ I **DO** authorize that information about my care may be disclosed or released to (e.g. to family member or close friend):

Name _____ Relationship to Patient: _____

Name _____ Relationship to Patient: _____

Patient Name (Printed) of Patient or Representative: _____

Signature of Patient or Representative: _____ Date: _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

We are dedicated to maintaining the privacy of your protected health information (PHI.) Federal and state laws ensure the privacy of your medical records, their availability to you, and specific rights regarding your medical records. In addition to your authorization, we may use or disclose your health information in accordance with the law under certain circumstances.

In an effort to reduce excess use of paper, the complete patient privacy practices notice is available online at www.californiadigestivecare.com. Below is a summary of how we collect, use, communicate, disclose and make use of personal information.

Outline of Our Privacy Policy:

- Before or at the time of collecting personal information, we will identify the purposes for which the information is being collected.
- We will collect and use personal information solely with the objective of fulfilling those purposes specified by us and for other comparable purposes, unless we obtain the consent of the individual concerned as required by law.
- We will only retain personal information as long as necessary for the fulfillment of those purposes
- We will collect personal information by lawful and fair means and, were appropriate, with the knowledge or consent of the individual concerned
- Personal data should be relevant to the purposes for which it is to be used, and, to the extent necessary for those purposes, should be accurate, complete, and up-to-date.
- We will protect personal information by reasonable security safeguards against loss or theft, as well as unauthorized access, disclosure, copying, use or modification.
- We will make readily available to customers information about our policies and practices relating to the management of personal information

I have carefully read, understand, and agree with California Digestive Care's **Complete** Patient Privacy Agreement, not only the summary included here. I understand that I may obtain a copy online any time at: www.californiadigestivecare.com. I understand that a paper copy is also available to me upon request the next time I receive services at one of their offices or by contacting the office directly at (925) 322-2372 to have a written copy mailed to me.

Patient Name (Printed) of Patient or Representative: _____

Signature of Patient or Representative: _____ Date: _____

Please choose 1 of the following:

____I DO wish to receive a printed copy of the complete patient privacy practices notice at this time.

____I DO NOT wish to receive a printed copy of the complete patient privacy practices notice at this time.

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Email Communication Consent Form

Risks of using email

For the ease of our patients, our office would like to offer the opportunity to communicate by email. Transmitting patient information poses several risks and the patient should not agree to communicate with our practice via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

• The privacy and security of email communication cannot be guaranteed.

• Email senders can misaddress, resulting in it being sent to many unintended recipients.

• Employers/online services may have a legal right to inspect and keep emails that pass through their system.

• Even after deletion of the email, back-up copies may exist on a computer.

• Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email.

• Emails can introduce viruses, generally damage, or disrupt the computer.

• Email can be used as evidence in court.

Conditions of using email

Our office will use reasonable means to protect the security and confidentiality of email information sent and received—however, we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing, and communication. Consent to use email includes agreement with the following conditions:

• Emails to or from the patient concerning treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, authorized individuals will have access the medical record/email.

• Although our office will endeavor to read and respond promptly to all emails from the patient, **it is not guarantee that any particular email will be read and responded to within any particular period of time. The patient should not use email for medical emergencies or other time- sensitive matters**.

I acknowledge that I have read and fully understand this consent form.

Patient Name or Representative (Printed) : _____

Signature of Patient or Representative: _____ Date: _____