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!

Patient Demographics

Patient Last Name:	Patient First Name:	Patient MI:
Preferred Name:	SSN:	Date of Birth:
Gender:	Age:	Race / Ethnicity:
Patient Address:	City & Zip Code:	Driver's License:
Cell Phone:	Home Phone:	Work Phone:
Email address:	Marital Status:	Occupation:
Guarantor:	Phone:	Circle: Home / Cell / Work
Emergency Contact:	Phone:	Circle: Home / Cell / Work
Referring Physician:	Primary Care Physician:	Preferred Language:

Primary Insurance Coverage:

Carrier:	Plan ID / Name:	Effective Date:
Group ID / Name:	Member Policy ID #:	
Subscriber Name:	Subscriber DOB:	Patient 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:	Patient Relationship to Subscriber:
Subscriber Employer:	Claims Address:	Carrier Phone:

The above information is true and correct. I understand that I am financially responsible for any charges, including balances not covered by my insurance. I will pay those balances due within 20 days of receipt of a statement. If collections become necessary, I will be responsible for any cost incurred.

Signature of Patient or Representative: ______________________________ Date:________________

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

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: ____

____

California Digestive Care

Gastroenterology & Advanced Endoscopy

Rishi Sharma M.D. - Cynthia Mullen M.D.

A Division of BASS Medical Group

Height: ______ Weight: ______

Review of Systems:

General

___Weight loss
___Weight gain
___Chills
___Fever

Gastrointestinal (Digestive)

___Poor appetite
___Trouble swallowing
___Pain with swallowing
___Heartburn
___Regurgitation food
___Nausea
___Vomiting
___Vomiting blood
___History peptic ulcer disease
___Bloating
___Abdominal pain
___Gallbladder surgery
___Abdominal surgery
___Liver disease
___Hepatitis
___Blood transfusion
___Jaundice
___Pancreatic disease
___Diarrhea
___Constipation
___Black colored stool
___Diverticulosis
___History of colon polyp/cancer
___Blood in stool
___Mucus in stool
___Fecal incontinence
___Anal pain or itching
___Anal fissure

Respiratory

___Frequent cough
___Bloody sputum
___Wheezing

Cardiovascular

___Chest pain
___Shortness of breath
___Heart attack
___High blood pressure
___Heart murmur

Locomotor/Musculoskeletal

___Muscle pain/weakness
___Joint pain /swelling
___Back pain

Genitourinary

___Urinary burning sensation
___Blood in urine

Neuro-Psychiatric

___Depression
___Anxiety
___Dizziness
___Seizures
___Substance Abuse

Neck

___Stiffness
___Enlarged glands

Other:________________________________

Head, Eyes, ears, Nose, Throat

___Headache
___Ear ache
___Impaired hearing
___Sore Throat
___Throat Clearing
___Glaucoma

Hematological

___Slow to heal after the cuts
___Anemia
___Iron deficiency
___Abnormal bruising
___History of excessive bleeding after tooth extraction or surgery

Endocrine

___Hormone therapy
___Hot intolerance
___Cold intolerance
___Thyroid disease
___Diabetes

Gynecological

___Vaginal discharge
___Abnormal vaginal bleeding
___Heavy Menstrual periods
___Menopause

Skin

___Tattoos
___Rash, hives, eczema
___Abnormal pigmentation

Preferred Pharmacy:____

Name *Address* *Phone*

Patient Name (Printed) of Patient or Representative: ____

Signature of Patient or Representative: ____ Date: ________________

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: $100-$150 for office appointments and $250-$500 for procedures (based upon the type of appointment cancelled/missed) 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: _______________

BILLING CATEGORY ASSIGNMENT OF BENEFITS FORM

During the course of your evaluation and treatment, physicians and professionals outside of BASS Medical Group may be involved in your care. Following a procedure, such as endoscopy or colonoscopy, it is common to be billed for physician services, anesthesia services, pathology services (if a biopsy was taken) and facility fees. **Each entity will bill separately for services provided.** You are free to utilize any health care facility or provider of your choice, subject to the restrictions of your physician's affiliation or restrictions which may exist under your health insurance coverage.

Patients should check with their health insurance provider if they have any questions or concerns about their coverage.

BASS Medical Group and Affiliated Organizations*

Physician Billing	**Facility Billing** *(one of the following)*	**Anesthesia Billing**	**Pathology Billing** *(one of the following)*
BASS MEDICAL GROUP	SHADELANDS ADVANCED ENDOSCOPY INSTITUTE ASPEN SURGERY CENTER JOHN MUIR MEDICAL CENTER	MEDICAL ANESTHESIA CONSULTANTS	PRECISION PATHOLOGY CONTRA COSTA PATHOLOGY ASSOCIATES ASSOCIATED PATHOLOGY MEDICAL GROUP

*Affiliated Organizations are subect to change without prior notification

1. I understand that the companies above will disclose my personal health information (PHI) for insurance and treatment purposes only. I am allowing the release of all PHI necessary for payment and treatment of my specific health problem.
2. 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. Billing from the facility, anesthesiologist or pathologist will be handled separately by those entities.
3. 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: _______________

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
Initial 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
Initial 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
Initial

or

_____ I **DO** authorize that information about my care may be disclosed or released to (e.g. to family
Initial 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: ______________

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.