California Digestive Care

Gastroenterology & Advanced Endoscopy

Rishi Sharma M.D. · Cynthia Mullen M.D.

A Division of BASS Medical Group

Dear Returning Patient:

Welcome Back!

We are committed to helping you get the most out of every visit. If it has been a year or more since we have last seen you, we need to update your information.

Thank you once again for helping us to serve you better.

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

√ Completed Returning Patient Information Forms, Patient History Forms & Signed Notice of Privacy Practices (see below)

√ Current 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

√ For patients enrolled in HMO plans, a new 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.

When to Arrive for Your Appointment:

You should arrive **at least 10 minutes prior** to your appointment time if you have not already completed your form. Please arrive **at least 5 minutes** ahead of time if your form has already been completed. This will ensure that you spend as much of your appointment time as possible with your provider instead of filling out paperwork.

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

We look forward to seeing you soon.

Drs. Mullen, Sharma, and the entire California Digestive Care Team

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RETURNING PATIENT REGISTRATION

Patient Name _____ DOB _____/_____/_____

Address _____ City _____ Zip Code _____

Phone Number _____ Cell / Home / Work OK to leave messages? Y N

Email Address_____

Emergency Contact _____ Phone Number _____

Primary Care Physician _____ Referred by _____

PATIENT HISTORY UPDATE

Have you had any changes in your **health or symptoms** we should be aware of since your last visit?

Please list your **current medications** and dosages:

Have you had any changes to your **medical or surgical history**?

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 receiving a statement. If collections become necessary, I will be responsible for any costs incurred.

Signature of Patient or Representative: _____ Date: _____

Patient Name or Representative (Printed): _____

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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 $500 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: _____