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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Patient Demographics Update

Patient Name:		
Cell phone:	Please circle your preferred phone	Other phone:
OK to leave a message? (Circle All that apply)	Home / Cell / Work / Other?	
Preferred email address:		
Mailing Address:		City & Zip Code:
Any Changes to Your Emergency Contacts? If so, name:		phone #:
Any Changes to Contacts allowed to receive information about you care? If so, name & phone #:		

Patient History Update

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

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

Are there any **other changes** in your **health or symptoms** we should be aware of since your last visit with us?

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.

Patient Name or Representative (Printed) : _____

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: $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: _____

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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: _____