

**Patient Registration  
Digestive Disease Consultants &  
Endoscopy Center of Northern Ohio, LLC.**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ [ ] Male [ ] Female Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Allergies: \_\_\_\_\_ E-mail address: \_\_\_\_\_

May we leave a message at your home with other residents [ ] Yes [ ] No On your answering machine/voice mail [ ] Yes [ ] No

Who may we talk to about your medical concerns: \_\_\_\_\_

Relationship(s) \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor (PCP): \_\_\_\_\_ May we provide him/her with update information [ ] Yes [ ] No

Employer/School \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name & Date of Birth: \_\_\_\_\_ Spouse's Employer & Work #: \_\_\_\_\_

\*Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
\*Someone with a **DIFFERENT PHONE NUMBER** than yours)\*

\*\*Responsible Party for Insurance and Bills: [ ] Patient [ ] Spouse [ ] Parents [ ] Mother [ ] Father [ ] Other \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Relationship to Card Holder: [ ] Self [ ] Spouse [ ] Dependent Card Copied: [ ] Yes [ ] No Co-payment: \$ \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

\*\*For MINORS ONLY \*\* Child Lives With: [ ] with both parents [ ] Mother [ ] Father

Mother/Guardian: \_\_\_\_\_ Address (if different): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father \_\_\_\_\_ Address (if different) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

\*\*Name of Specialist Physician\*\* (NOT my family physician) involved with my medical care whom I authorize ongoing release of information for continuity of care:

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Type of Physician/ health care provided: \_\_\_\_\_



**Digestive Disease Consultants &  
Endoscopy Center of Northern Ohio, LLC.**

Practice Privacy Statement – effective date: February 18, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION: PLEASE REVIEW IT CAREFULLY**

- I.** This is a formal notification, as required by the government concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as “PHI” or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about release of information. **You can change this information at any time with either written notification or verbal notification, followed up in writing.** Changes can only impact the care or information from that point in time forward.
- II.** Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:
- For your treatment in this practice and other locations under our immediate care for gastroenterology care. This may include any referral for services such as lab work, x-rays, endoscopes, and other diagnostic tests or treatment related to your medical care needs.
  - For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.
  - For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
  - Appointment reminders and health related benefit services only with your consent identified on the registration form
  - Disclosure to your family and friends concerning any related health care information with your consent on the registration form which can be modified at any time orally, followed by written consent.
  - **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.**

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies. An example would be victims of abuse
- Information used for public health purposes, medical examiners or related to a person’s death or for the health department for disease tracking. Specific governmental functions
- Information used for health care oversight, such as a site review by an insurance program.

- III.** Your rights for your health information include: The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI, but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.
- IV.** This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.
- VI.** If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Office Manager in our Business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Office of Civil Rights - Regional Manager  
Department of Health & Human Services  
Chicago, Illinois 60601  
(312) 886-1807

CIGNA Government Services  
1 Cameron Hill Circle, Suite 0061  
CHATTANOOGA, TN 37402-0061  
(866) 290-4036

Patient signature on receipt of Privacy Notice: X Date: X

Patient unable to sign due to: \_\_\_\_\_ [ ] Refused to sign Date: \_\_\_\_\_

Digestive Disease Consultants &  
Endoscopy Center of Medina Inc.

Privacy Consent – For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to DDC & Endoscopy Center of Medina to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

**Consent for treatment:** I, with my signature, authorize ( this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

**Consent for release of information for payment and operations:** I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

**Consent related to the Privacy Notice:** I have had a chance to review and Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient/Guardian: X

Date: X

Name printed: X

If not patient, relationship: \_\_\_\_\_

Copy of Practice Privacy statement signed or initiated with patient/guardian on: \_\_\_\_\_

Patient unable to sign privacy statement due to: \_\_\_\_\_

**Revocation:**

I hereby revoke the consent given above:

Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Name printed: \_\_\_\_\_

If not patient, relationship: \_\_\_\_\_

**Consent for assignment of benefits:** I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Patient/Guardian initial: X

Date: X



# Welcome to Our Practice

Please fill out the information found below to the best of your ability

Date of Birth \_\_\_\_\_ Physician \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Why are you here today? \_\_\_\_\_

## Patient Medical History

Have you ever had the following (check "no" or "yes," leave blank if uncertain.):

Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Plasma Transfusions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mitral Valve Prolapse	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood Transfusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Low Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hemorrhoids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Peptic Ulcer Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Migraine Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heart Attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Overactive Thyroid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stents Placed	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Underactive Thyroid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	AIDS or HIV+	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bleeding Tendency	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If Yes, what kind? _____			Infectious Mono	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Any Other Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Polio	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Atrial Fibrillation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(please list) _____		
Glaucoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sleep Apnea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____		
Hiatal Hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Use CPAP	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____		
Inguinal Hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Defibrillator	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____		
Incisional Hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Pacemaker	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____		

Previous Surgeries/Serious Illnesses	When	Hospital, City, State/Province
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When was your last upper endoscopy? \_\_\_\_\_

When was your last colonoscopy? \_\_\_\_\_

## Patient Social History

Marital Status:  Single     Married     Separated     Divorced     Widowed

Occupation: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Use of alcohol:  Never     Number of drinks weekly \_\_\_\_\_

Use of tobacco:  Never     Previously, but quit \_\_\_\_\_     Current packs/day \_\_\_\_\_

Use of illegal drugs:  Never     Type/frequency \_\_\_\_\_

## Family Medical History

Any Family Medical History of:  Colon Cancer     Stomach Cancer     Peptic Ulcer Disease     Irritable Bowel Syndrome     Colon Polyps

Diverticulitis     Crohn's Disease     Ulcerative Colitis     Celiac Disease

Illnesses or Cause of Death

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brother \_\_\_\_\_

Sister \_\_\_\_\_

Spouse \_\_\_\_\_

Children \_\_\_\_\_

Other \_\_\_\_\_

PLEASE  
TURN  
OVER

# Review of Systems: Please indicate any personal history below

## CONSTITUTIONAL SYMPTOMS

- Good general health lately  No  Yes  
 Recent weight change  No  Yes  
 Fever  No  Yes  
 Fatigue  No  Yes

## EYES

- Eye disease or injury  No  Yes  
 Wear glasses/  
 contact lenses  No  Yes

## EARS/NOSE/MOUTH/THROAT

- Hearing loss or ringing  No  Yes  
 Earaches or drainage  No  Yes  
 Chronic sinus problems  
 or rhinitis  No  Yes  
 Wear a Hearing Aid  No  Yes  
 Nose bleeds  No  Yes  
 Mouth sores  No  Yes  
 Bleeding gums  No  Yes  
 Bad breath or bad taste  No  Yes  
 Sore throat or voice change  No  Yes  
 Swollen glands in neck  No  Yes  
 Dentures  No  Yes

## CARDIOVASCULAR

- Heart trouble  No  Yes  
 Chest pain or  
 angina pectoris  No  Yes  
 Palpitation  No  Yes  
 Swelling of feet,  
 ankles or hands  No  Yes

## RESPIRATORY

- Chronic or frequent coughs  No  Yes  
 Spitting up blood  No  Yes  
 Wheezing  No  Yes

## GASTROINTESTINAL

- Loss of appetite  No  Yes  
 Change in bowel  
 movements  No  Yes  
 Nausea or vomiting  No  Yes  
 Frequent diarrhea  No  Yes  
 Painful bowel movements  
 or constipation  No  Yes  
 Rectal bleeding or  
 blood in stool  No  Yes  
 Abdominal pain  No  Yes

## GENITOURINARY

- Blood in urine  No  Yes  
 Incontinence or dribbling  No  Yes  
 Kidney Stones  No  Yes  
 Recurrent Bladder Infections  No  Yes

## MUSCULOSKELETAL

- Joint pain  No  Yes  
 Back pain  No  Yes

## INTEGUMENTARY

- Rash or itching  No  Yes  
 Change in skin color  No  Yes  
 Change in hair or nails  No  Yes

## NEUROLOGICAL

- Frequent or recurring  
 headaches  No  Yes  
 Light headed or dizzy  No  Yes  
 Numbness  No  Yes  
 Tremors  No  Yes

## PSYCHIATRIC

- Memory loss or confusion  No  Yes  
 Nervousness  No  Yes  
 Depression  No  Yes  
 Insomnia  No  Yes

## ENDOCRINE

- Glandular or hormone  
 problem  No  Yes

## HEMATOLOGIC/LYMPHATIC

- Slow to heal after cuts  No  Yes  
 Bleeding or bruising  
 tendency  No  Yes  
 Anemia  No  Yes  
 Past transfusion  No  Yes

## ALLERGIC/IMMUNOLOGIC

- History of skin reaction or other adverse  
 reaction to:  
 Penicillin or other  
 antibiotics  No  Yes  
 Morphine, Demerol,  
 or other narcotics  No  Yes  
 Novocain or other  
 anesthetics  No  Yes  
 Aspirin or other pain remedies  No  Yes  
 Tetanus antitoxin or  
 other serums  No  Yes  
 Iodine, merthiolate or  
 other antiseptics  No  Yes  
 Other drugs/medication/allergies:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Known food allergies: \_\_\_\_\_

Environmental allergies: \_\_\_\_\_

## AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

X

Signature of patient (or parent/guardian if minor)

Date



## Digestive Disease Consultants

Bipin K. Sharma, M.D., MRCP (U.K.)  
David B. Myers, M.D.  
Fadi N. Bashour, M.D.  
Richard A. Del Rio, M.D., M.S., M.B.A.  
Maya G. Merheb, M.D.

1299 Industrial Parkway North  
Suite 110  
Brunswick, OH 44212

970 East Washington Street  
Suite 204  
Medina, OH 44256

500 E. Royalton Road  
Suite 100  
Broadview Hts, OH 44147

### BILLING POLICY

**We now require all deductibles and co-pays be paid prior to or at the time of service.**

Any outstanding balances are to be paid in full within a 90 day grace period. All accounts over **90 days old are subject to a monthly interest charge of 1.5%, annual rate of 18%.**

Please make every effort possible to satisfy balances accordingly to avoid accumulating interest and possibly having you account turned over to a collection agency. **Patients who have their accounts turned over to a collection agency are discharged from our Practice, and are subject to an additional \$25.00 collection fee.**

If you have any questions regarding this policy please speak to a member of our Billing department.

I have read this policy in full; I understand and agree to the terms of this policy.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_