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:_____ Family Doctor (PCP):_____

How may we leave messages: On your answering machine/voice mail [ ]Yes [ ] No Text Messaging [ ] Yes [ ] No

Email [ ]Yes [ ] NO Email Address:_____

Names of who we may we talk to about your medical concerns_____

_____Relationship(s) _____

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:	PHARMACY NAME / CITY:
DR: SHARMA MYERS BASHOUR DEL RIO or MERHEB	PHARMACY NUMBER:

DO YOU HAVE A MAIL ORDER PRESCRIPTION PROGRAM? YES NO

IF YES WITH WHOM: _____

TODAY'S DATE:_____ PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS.

Name of Medication	Prescribed by	Dose	How many times a day taking	Why taking

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 _____

Digestive Disease Consultants

Welcome to Our Practice

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

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

3985 Medina Road
Suite 120
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: _____