Digestive Disease Clinic & Endoscopy Center

715 North Weber Street, Suite 100
Colorado Springs, CO 80903
Phone: (719) 473-6115
Fax: (719) 473-3688
www.ddc95.com

Abbass Shafii, M.D.

PATIENT DEMOGRAPHICS

Please Print & fill in ALL blanks

NAME:_____ _____ _____
First MI Last

ADDRESS:_____ _____
Street Apt/Ste/Lot

_____ _____ _____
City State Zip

DATE OF BIRTH:_____/_____/_____ SSN:_____-_____-_____ SEX: M_____ F_____
Month Date Year

HOME PHONE: (____) _____-_____ WORK PHONE: (____) _____-_____ OTHER: (____) _____-_____
Cell / Home (please circle)

E-MAIL: _____ PREFERRED CONTACT METHOD: e-mail or postal mail

MARTIAL STATUS: Single_____ Married_____ Widowed ____ Divorced____ Separated____ Domestic Partner____
SPOUSE/PARTNER: _____ CONTACT NUMBER: (____) _____-_____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT(other than spouse/partner):_____ Contact #: (____) _____-_____
Relationship: _____

REFERRING DOCTOR:_____PRIMARY CARE DOCTOR:_____

PHARMACY:_____ location or phone #:_____
LABORATORY:_____ location_____

INSURANCE INFORMATION: (we will need a copy of all insurance cards)
If your insurance company requires a referral, YOU ARE RESPONSIBLE for obtaining it.

PRIMARY INSURANCE_____ ID#_____GROUP #_____

Name of Policyholder (**required**)_____ Date of Birth **(required)**____/_____/_____

SECONDARY INSURANCE_____ ID#_____ GROUP#_____

Name of Policyholder **(required)**_____ Date of Birth **(required)**_____/_____/_____

ASSIGNMENT OF BENETITS

I am aware that I am responsible for ALL the charges incurred for the care of the above named patient. I agree that payment will not be delayed or withheld because of insurance coverage or pending commercial insurance claims and that all proceeds of the insurance are assigned to the **Digestive Disease Clinic** or **Digestive Disease Endoscopy Center.** I hereby authorize payment directly to the **Digestive Disease Clinic** or **Digestive Disease Endoscopy Center** for the medical benefits otherwise payable to me. I authorize the release of any medical information necessary to process my insurance claims.

SIGNATURE OF RESPONSIBLE PARTY_____ **DATE** _____

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_____ Yearly Update _____New patient _____ Procedure Update

PLEASE FILL IN ALL THE BLANKS

Patient's Name (print)_____ Reason for visit_____
Primary Care Physician_____Referring Physician_____

☐ None Known Medication Allergies ***OR*** Allergies /Adverse Drug Reactions ☐ Tape ☐ Latex ☐ Medications _____

_____

LIST *ALL* MEDICATIONS YOU TAKE (PRESCRIPTION OR OVER THE COUNTER - INCLUDING ASPIRIN & IBUPROFEN)

NAME	DOSE/FREQUENCY	NAME	DOSE/FRQUENCY

Check Yes or No for each item	Yes	No	Comments	Check Yes or No for each item	Yes	No	Comments
Loss of appetite				**General**			
Difficulty Swallowing				Anemia/Sickle Cell Disease			
Heartburn				Bleeding easily(bruising)			
Belching of excess gas				Blood Clots/Phlebitis			Where?
Bloating				Cancer			Type
Nausea				Headaches/Migraines			
Vomiting				HIV/AIDS			
Rectal bleeding				Fibromyalgia			
Constipation (change)				**MRSA**			When?
Diarrhea (chronic)				Arthritis/Joint swelling			
Hemorrhoids				Seizures/Epilepsy			
Polyps (colon or stomach)				Sexually transmitted disease			
Weight loss or gain			Specify	Thyroid disease			
Food intolerance				Kidney disease/stones			
Black, tarry stools				Fainting/Dizziness			
Change in bowel habits				Head/Neck/Back injuries			
Hepatitis/Jaundice				Strokes/TIA's			
Colitis				MS (Multiple Sclerosis)			
Abdominal Pain				History of Blood Transfusions			
Location?				Tattoos			
For how long?				Body Piercings			
C-Diff				**Diabetes** – Type I or II			IDDM or NIDDM
Heart Disease				Managing physician			
Angina-chest pain w/exercise				Blood glucose monitoring:			
Heart disease-heart attack			Year?	How often / Range			/
Heart murmur							
High or low blood pressure			Specify	**Lung Disease**			
Mitral Valve Prolapse				[1]Asthma [2]COPD [3]Emphysema			Specify: 1 2 3 (circle)
Palpitations-irregular beats				Bronchitis – chronic cough			
Pacemaker or Defibrillator			Specify	Shortness of breath at rest			
A-Fib				Oxygen use			Flow rate liters
Male: Prostate disorders				Tuberculosis			
Female: Could you be pregnant?				Sleep Apnea			
Last menstrual period?				C-Pap or Bi-Pap			Specify
Hysterectomy/ Tubal ligation			When?	Narcolepsy			
				[1]Depression [2]Anxiety [3]PTSD			Specify: 1 2 3 (circle)

DATE

History and Physical (continued) **Patient's Name (print)**_____

PLEASE ANSWER *ALL* OF THE FOLLOWING

ADDITIONAL QUESTIONS:	**YES**	**NO**	**COMMENTS**
Alcohol use?			Amount:
Caffeine use?			Daily intake:
Recreational drug use?			
Current smoker/tobacco use?			Amount:
Marijuana Use? Smoking / Edible?			Use:
Ex-smoker? Year quit? _____			How many packs per day?_____ How many years smoked?_____
Do you have any loose, chipped or crowned teeth? Bridgework or dentures?			
Do you wear a hearing aid?			
Any Other Diagnosis or Medical Conditions not mentioned?			

FAMILY HISTORY: (Colon or Breast Cancer, Heart Disease, Diabetes and/or Hypertension)

	Age	Medical Problems	If deceased, cause?
Father			
Mother			
Brother(s)			
Sister(s)			

PAST ENDOSCOPY HISTORY

Procedure	Date
Flex Sig	
EGD	
Colonoscopy	
ERCP	
Liver Biopsy	
Cholesterol Test	

HOSPITALIZATIONS / SURGERIES	**PHYSICIAN**	**YEAR**

HOSPITALIZATIONS / SURGERIES	**PHYSICIAN**	**YEAR**

PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**

OFFICE PHYSICIAN USE

I. Physical Exam: BP_____ Pulse: ☐ Regular ☐ Irregular/Rate_____Weight_____Height_____ Resp_____

Mental Status: ☐ Alert & Oriented x 3 or describe _____ Temp._____

Age_____

Lungs: ☐ Clear to auscultation Anterior/Posterior or describe_____

Heart: ☐ No murmur or gallup or describe _____

Abdomen: ☐ Soft, non-tender, no masses or organomegaly or describe _____

Rectal exam: ☐ GUIAC: ☐ Positive ☐ Negative / BPH ☐ Yes ☐ No Mass: ☐ Yes ☐ No

II. Impression:

III. Plan:

PHYSICIAN ORDERS (PREPROCEDURAL)_____

_____

_____

PHYSICIAN/PRACTIONER SIGNATURE **DATE**

DATE

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PATIENT CONFIDENTIALITY NOTICE

It may be necessary for the Digestive Disease Clinic & Endoscopy Center staff to leave a phone message regarding your appointments, results and medical care at our clinic**. Please provide the phone number(s) in the space(s) below where you are granting us permission to leave messages.**

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Our office places courtesy appointment reminder calls prior to your appointments with our office. Please provide a preferred phone number where appointment reminder messages may be left:

Phone: (_____) _____

Release of Medical Information

If you grant us permission to leave messages with and/or discuss your medical information with anyone other than yourself, you must complete the following:

_____ **YES,** you are allowed to release my medical information to ONLY the following:

Name/Relationship: _____ / _____ Phone: _____

Name/Relationship: _____ / _____ Phone: _____

Name/Relationship: _____ / _____ Phone: _____

OR

_____ **YES,** you are allowed to release my medical information to **ANYONE**.

OR

_____ **NO,** you are NOT allowed to release or discuss any of my medical information with anyone other than myself.

_____

PRINTED NAME **SIGNATURE** **DATE**

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FINANCIAL & OFFICE POLICIES

1. Forms of Payment

- Cash, Check,
- Money orders,
- American Express, Discover, MasterCard & Visa.

2. Office Appointments: Cancellations, No Shows & Late Arrivals

- Please cancel all appointments at least 48 hours in advance.
- A No Show is any scheduled appointment that you do not show up for or do not cancel 48 hours prior to the appointment.
- 1st No Show charge is $50.00,
- 2nd No Show charge is $75.00,
- 3rd No Show charge is $100.00 and a review of account for termination.
- If you are late for your appointment, the provider will decide whether or not to see you. If you are seen, you will be worked into the schedule. Patients who are on time for their appointments will be seen first.
- **Patients that No Show or cancel without 48 hours notice for a scheduled GI procedure (i.e. colonoscopy, EGD, ERCP, etc.) will be charged $150.00.**

3. Patient Insurance Responsibility

- **If you have a co-payment or co-insurance, it is to be PAID IN FULL at the time of service.** This is mandated by your insurance company and is our requirement as well.
- **You, the patient, are responsible to know what your insurance benefits are, this includes: co-payment & co-insurance amounts, deductible amounts and preauthorization guide lines.**
- It is the responsibility of the patient to notify the office as to **all** current medical insurances; this includes any secondary insurance. We do not file tertiary insurances.
- The patient is responsible to be certain that the information given to the office is correct and accurate. All medical insurance cards are mandatory at check-in time.
- All patients are required to sign in & pay their co-payments/co-insurances prior to receiving any service or must make prior payment arrangements with our Billing Department.
- If your insurance company requires a referral, it is your responsibility to obtain the referral.
- If you do not have your co-payment/co-insurance or referral on the date of service, please reschedule your appointment.
- If no insurance information is given at the time of service, or if there is no insurance, you will be responsible for the entire bill at the time of service, unless you have made **prior arrangements** with our Billing Department.

4. Overdue Balances

- All balances that are your responsibility are due within one month of receipt of the statement.
- Overdue balances that go past a month are subjected to a rebill fee up to $30.00 for any subsequent statements.
- After the second statement, the account may be turned over to an outside collection agency.
- All patient accounts are reviewed for termination due to non-payment.

I understand all the provisions as listed above.

Date_____

Printed Name_____

Signature of patient or responsible person: _____

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CORHIO Colorado Regional Health Information Organization

Patient Notification of CORHIO Participation

This notification will describe how your medical information may be used and disclosed, and how you may access this information.

PLEASE READ IT CAREFULLY

About CORHIO

CORHIO is the state-designated entity for Health Information Exchange (HIE). CORHIO is a nonprofit organization dedicated to improving quality of health care for Colorado residents through a HIE.

What is a Health Information Exchange?

Health Information Exchange is a method of securely and electronically sharing personal health and medical information between doctors, hospitals and other healthcare providers, when needed for patient care. Health information is protected and exchanged under the Health Insurance Portability and Accountability Act (HIPAA) standards. Health Information Exchange allows secure electronic access for patients and physicians; to make sure patient information is accessible when and where it is needed.

Patient safety and quality of care is improved by having access to the Health Information Exchange. It is beneficial for health care providers to have access to all of your health information to aid in an accurate diagnosis and treatment plan. Each of your providers may have a different portion of your medical information. However, when each provider has access to all of your history and treatment plans, they are able to provide a better care plan for you. Being able to share your health information may also reduce your costs by reducing duplicate tests or procedures.

Through CORHIO's HIE, some or all of your medical information, from the Digestive Disease Clinic and Endoscopy Center, **may be** transmitted electronically (once the connection is in place) and shared with other doctors or hospitals that participate in the HIE. CORHIO's HIE enables emergency medical personnel and providers with immediate access to your medical information, that may be critical to your care.

Your electronically shared health information is tracked by: person(s) accessing your information, types of information accessed, how and when it was used, and how it is stored. This tracking procedure makes it much harder for anyone to misuse your medical information versus faxing or paper documents.

CORHIO and Participating Health Care Providers Obligations

CORHIO and all organizations participating in the HIE must comply with applicable state and federal laws that protect the privacy and security of medical and personal information.

Rights for Accessing Your Medical Information Being Exchanged

You have the right to access and receive a copy of your medical information, under HIPAA guidelines. You, also, have the right to receive an accounting of how your medical information has been disclosed as part of the HIE.

"Opting Out" of the CORHIO Health Information Exchange

Participating in this Health Information Exchange (HIE) is voluntary; your decision to participate or not - will not impact your health plan benefits or coverage. If you **DO NOT** want other providers, hospitals or facilities outside of the Digestive Disease Clinic and Endoscopy Center to have access to your Electronic Health Information for treatment, you may **"opt out"** of this program by filling out a ***Health Information Exchange Opt-Out Request Form*** provided by this health care provider.

By signing below – you are acknowledging participation in CORHIO Health Information Exchange

_____ _____ _____

Printed Name Signature Date