CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Digestive Disease Consultants

PATIENT INFORMATION FORM

Date: _____

Patient Last Name:	Patient First Name, M.I.:
Patient Date of Birth:	Sex: ☐ M ☐ F
Age:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Partnered
Patient Address:	Home Phone:
City, State, Zip	Cell Phone
Email Address:	Work Phone:
Emergency Contact:	Primary Care Physician (PCP):
Phone Number:	
Relationship:	Phone Number:

PRIMARY INSURANCE COVERAGE

Carrier:	Member ID #:
Claims Address:	Group #:
Relationship to Policy Holder: ☐Self ☐ Spouse ☐Child ☐Other	
Policy Holder Information (If other than self)	
Policy Holder Name:	Policy Holder Date of Birth:
Sex: ☐ M ☐ F	

SECONDARY INSURANCE COVERAGE

Carrier:	Member ID #:
Claims Address:	Group #:
Relationship to Policy Holder: ☐Self ☐ Spouse ☐Child ☐Other	
Policy Holder Information (If other than self)	
Policy Holder Name:	Policy Holder Date of Birth:
Sex: ☐ M ☐ F	

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ASSIGNMENT OF BENEFITS & PAYMENT/CREDIT AGREEMENT
(This is necessary to facilitate the processing of insurance claims and assure payment.)

1. I hereby authorize and give permission for Capital Digestive Care (CDC) to disclose my personal health information (PHI) for insurance and treatment purposes only. I am allowing CDC to release PHI necessary for payment and treat 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.
3. I understand that I am financially responsible for all charges not paid by said insurance company, including any deductibles and co-pays, and that co-pays are due at the time services are rendered.
4. I understand and agree that in the event I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and I agree to pay collections agency's fees for collection, court costs, and/or reasonable attorney fees that may be incurred in the collection of an outstanding balance.
5. This office reserves the right to charge a handling fee for any unpaid balance.

I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Signed: _____ Date:_____

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Complete Patient History Form

Name:_____Date of Birth:_____

The following information is **very important to your health**. Please take time to fully and completely fill out this important information. We are counting on you!

o **Reason for visit**_____

_____

Race

o White/Caucasian	o Black or African American	o Asian	o Hispanic or Latino
o American Indian or Alaska Native	o Native Hawaiian or Other Pacific Islander	o Mixed	o Other
o Unknown	o Patient Declines to provide information		

Ethnicity

o Hispanic or Latino	o Not Hispanic or Latino	o Patient Declines to provide information

Gender

o Male	o Female	o Other

Preferred Language

o English	o Spanish	o Other_____

Contact Preference

o Letter	o Other_____

o **What pharmacy do you want us to use for any medications that are prescribed?**

Pharmacy: _____

_____

Allergies

o Patient has no known allergies	o Patient has no known **DRUG** allergies	o Adhesive tape	o Codeine Sulfate
o Erythromycin	o Latex	o IV Contrast	o Penicillins
o Sulfa	o Shellfish	o Other_____	o Other_____

Complete Patient History Form

Name:_____Date of Birth:_____

Current Medications

o None

Name Dose How taken

_____

_____

_____

_____

_____

_____

_____

_____

_____

Immunizations

o None	o Flu vaccine When:_____	o Hepatitis A When:_____
o Hepatitis B When:_____	o Pneumovax When:_____	o TB Skin test When:_____

Diagnostic Studies

o None	o Colonoscopy When:_____	o Endoscopy/EGD When:_____
o CT Scan Abdomen/Pelvis When:_____	o MRI of Abdomen/Pelvis When:_____	o ERCP When:_____

Previous Procedures/Surgeries

o None	o Gallbladder removed	o Appendectomy	o Colon resection	o Small Bowel resection
o Exploratory Abdominal Surgery	o Gastric Bypass Surgery	o Lap Band Surgery	o Hemorrhoid Surgery	o Hemorrhoid Banding
o Abdominoplasty	o Hysterectomy	o Tubal Ligation	o Mastectomy	o Pacemaker Placement
o Defibrillator Placement	o Coronary Artery Bypass Graphing (CABG)	o Abdominal Aortic Aneurysm (AAA) Repair	o Heart Valve Replacement /Surgery	o Cardiac Catherization /Stent
o Joint Replacement	o Back Surgery	Other_____	Other _____	

Complete Patient History Form

Name:_____Date of Birth:_____

Past or Present Medical History

- **Gastroenterology/Hepatology**

o Colon polyps	o Colon cancer	o Irritable Bowel Syndrome	o Diverticulitis
o Crohn's Disease	o Ulcerative Colitis	o GERD /Reflux	o Barrett's Esophagus
o Ulcer Disease	o Hepatitis B	o Hepatitis C	o Fatty Liver Disease
o Cirrhosis/Liver	o Celiac Disease	o Bowel Obstruction	o Pancreatitis
o Anemia in the past	o Other _____	o Other _____	o Other _____

- **Cardiology**

o Coronary Heart Disease	o Heart Valve Disease	o Congestive Heart Failure	o Heart attack
o High Blood Pressure	o Atrial Fibrillation	o Vascular Disease	o High Cholesterol
o Stroke	o TIA (mini stroke)	o Other _____	

- **Pulmonary**

o C.O.P.D.	o Asthma	o Sleep Apnea
o Blood Clots (leg)	o Blood Clots (lung)	

- **Other**

o Anxiety Disorder	o Arthritis	o Bipolar Disorder	o Body Piercings
o Breast Cancer	o Current Pregnancy	o Depression	o Diabetes
o Fibromyalgia	o Gout	o HIV Exposure	o HIV Infection
o Hypothyroidism	o Kidney Disease	o Kidney Stones	o Lung Cancer
o Ovarian Cancer	o Other Cancer	o Prostate Cancer	o Recurrent Infections
o Seizures	o Skin Cancer	o Tattoos	Other_____

Complete Patient History Form

Name:_____Date of Birth:_____

Social History

o Single	o Married	o Divorced	o Separated
o Widowed	o Civil Union	o Unknown	o Other

I drink alcohol:	**I drink caffeine:**	**I use tobacco:**	**My drug use:**	**I exercise:**
____None _____Less than 7 per week _____More than 7 per week	(coffee, tea, cola, or other caffeinated drinks) _____None _____Occasionally _____Daily	(Circle) Cigarettes Cigars Chewing tobacco __Every Day __Only some days __Former smoker __Never smoked __Smoker, Current status unknown __Unknown if ever smoked	_____None _____Recreational drugs **currently** _____ Recreational drugs **in the past**	___None ___I exercise routinely

Family History

o No knowledge of family history

o **No one in my family has a history of**:

o Celiac Sprue	o Colon polyps	o Gallbladder Disease
o Liver Disease	o Stomach Cancer	o Colon Cancer
o Crohn's Disease	o Inflammatory Bowel Disease	o Polyps
o Ulcerative Colitis		

o **Someone in my family has a history of:** (please check all that apply)

	Mother	**Father**	**Sister**	**Brother**	**Grandmother**	**Grandfather**
Colon Cancer						
Colon Polyps						
Crohn's Disease						
Gallbladder Disease						
Liver Disease						
Ulcerative Colitis						
Stomach Cancer						

Complete Patient History Form

Name:_____Date of Birth:_____

What are your current symptoms today? (check all that apply)**:**

Allergic/Immunologic
- o Allergic reactions
- o Current infections

Cardiovascular
- o Chest pain
- o Irregular heart beat
- o Rapid heart rate/palpitations
- o Ankle swelling

Constitutional
- o Fever
- o Loss of appetite
- o Weight loss

ENMT
- o Nose bleeds
- o Loss of vision
- o Hoarseness
- o Mouth sores

Endocrine
- o Excessive thirst
- o Heat or cold intolerance

Musculoskeletal
- o Back pain
- o Joint pain/arthritis

Neurological
- o Dizziness
- o Fainting
- o Frequent headaches
- o Vertigo
- o Memory loss/confusion

Psychiatric
- o Depression
- o Anxiety/panic attacks

Respiratory
- o Frequent cough
- o Shortness of breath when at rest
- o Wheezing

Genitourinary
- o Blood in urine
- o Recent darkening of urine

Gastrointestinal
- o Abdominal pain
- o Abdominal swelling
- o Change in bowel habits
- o Constipation
- o Diarrhea
- o Gas
- o Heartburn
- o Nausea
- o Rectal bleeding
- o Stomach cramps
- o Vomiting
- o Difficulty swallowing
- o Yellowing of skin

Hematologic/Lymphatic
- o Easy bruising
- o Anemia

Integumentary (skin)
- o Itching
- o Rashes
- o hives

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FEDERAL LAW ENSURES THE PRIVACY OF YOUR MEDICAL RECORDS, THEIR AVAILABILITY TO YOU, AND SPECIFIC RIGHTS REGARDING YOUR MEDICAL RECORDS.

Digestive Disease Consultants complies with these standards. As a general principle, we will always assume that you have instructed us **NOT** to release your medical records, or any portion thereof, to anyone, except under the usual, general circumstances covered below.

Please read and sign this **GENERAL AUTHORIZATION CONCERNING YOUR MEDICAL RECORDS.**

Relevant portions of my medical record may be provided to:

1. other designated doctors and their staffs (e.g., this practice; primary or referring doctors and their staffs; hospital or out-patient facilities, endoscopy unit, or surgical-day-care).
2. my medical insurance company to document specific service(s) provided and billed.
3. the Government, as required by law (e.g., subpoena).

If you wish to designate (a) person(s) (other than those above) to be given access to all or part of your medical record, please initial "ACCESS ALLOWED" below and write their name.

____ **ACCESS ALLOWED Name(s):**_____
Initial *Please Print*

Please specify by circling the appropriate answer below, if we may leave health-related information (e.g., lab/biopsy/ x-ray results, billing issues, or other doctor-patient communications) on your:

Home answering machine: **Y** or **N**
Cell Phone voicemail: **Y** or **N**
Work voicemail: **Y** or **N**
Personal email: **Y** or **N** If yes, **e**mail address_____@_____
(Please print)

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____
Printed Name Date

_____ _____
Signature or Personal Representative Account No. (Office Use Only)

Revised 04.21.15

CAPITAL DIGESTIVE CARE
First in Digestive Health

Digestive Disease Consultants
14955 Shady Grove Road
Rockville, MD 20852

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice up on request

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Example of Treatment, Payment and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to authorized family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you for fundraising purposes, but you have the right to opt out of receiving such communications.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business Associates: We may disclose your health information to business associates or third parties that we have contracted with to perform agreed upon services.

We do not engage in selling your health information, however if we do, we will obtain your written authorization before we are permitted to sell your health information. In all other situations, including marketing activities, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to restrict disclosures of your health information to your health plan for payment and health care operations purposes (and not for treatment) if the disclosure pertains to a health care item or service for which you paid out-of-pocket in full. If requesting a restriction for a health care item or service for which you paid out-of-pocket in full, we will honor your request, unless the disclosure is necessary for your treatment or is required by law. For all other restriction requests, we are not required to agree to such restrictions, but, if we do agree, we must abide by those restrictions.

Confidential Communication: You may ask us to communicate with you confidentially by for example, sending notices to a special address or not using post-cards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or, important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting or Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment payment, or health care options.

Breach Notification: We are required to notify you in the event of a breach of your unsecured protected health information, and will do so

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or, you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, Please contact:

The Privacy Officer
14955 Shady Grove Rd
Suite 150
Rockville, MD 20852
(301) 340-3252

I _____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed _____ Date:

If not signed, reason why acknowledgement was not obtained:

Staff Witness seeking acknowledgement:

Date:

CAPITAL DIGESTIVE CARE℠
First in Digestive Health

12510 Prosperity Drive, Suite 200
Silver Spring, MD 20904

240.485.5200 PHONE
240.485.5291 FAX
capitaldigestivecare.com

Communications Notification

Email address (please print): _____

Telephone: (Home)_____ (Mobile)_____

Capital Digestive Care employs a number of different resources for the purpose of contacting you to deliver important information. Your privacy is important to us and we will not share or sell your information to any third-party vendor except when required for legal or debt collection purposes. Listed below are examples of some of the reasons we may need to reach you using the information we collect at the time of registration (for new patients) or have on file (for established patients), which may include your email address, home or mobile telephone number.

- **Patient Portal Access**: If you choose to create an account, you will be able to update your personal information before or after your appointment, view certain test results and send messages to your doctor and/or doctor's office.
- **Practice Announcements**: These may include new physician or provider announcements or provider retirement/relocation notifications.
- **Customer Service Improvements**: We are always evaluating applications to improve our service to you, including solutions to improve appointment scheduling, appointment reminders and procedure preparation. As the applications become available, you may receive a notification or registration invitation.
- **Digestive Health Information:** This may include information on new treatments or clinical research trials, notification of educational seminars on specific digestive health topics or other relevant information.
- **Collection Activity:** If your account becomes delinquent, Capital Digestive Care may employ the services of a collection agency to recover any outstanding balance on your account. You may request the removal of your mobile number for this purpose by providing written notification to Capital Digestive Care, ATTN: Billing Manager, 12510 Prosperity Drive, Suite 200, Silver Spring, MD 20904.

Patient Name (please print) _____

Patient Signature Date

WASHINGTON, DC

Metropolitan Gastroenterology Group
2021 K St, NW, Suite 500
202.296.3449

106 Irving St, NW, Suite 205S
202.829.0170

MARYLAND

Frederick County

IJAMSVILLE, MD
Birns, Gloger, Witten & Bhinder, MD
3280 Urbana Pike, Suite 204
301.810.5252

Howard County

COLUMBIA, MD
Maryland Digestive Disease Center
5500 Knoll North Drive, Suite 460
410.730.9363

Prince George's County

LAUREL, MD
Maryland Digestive Disease Center
7350 Van Dusen Rd, Suite 210
301.498.5500

Montgomery County

BETHESDA, MD
Metropolitan Gastroenterology Group
10215 Fernwood Rd, Suite 404
301.493.5210

CHEVY CHASE, MD
Metropolitan Gastroenterology Group
5550 Friendship Blvd, Suite T-90
301.654.2521

GERMANTOWN, MD
Capital Gastroenterology Consultants
20528 Boland Farm Rd, Suite 201
301.593.2002

OLNEY, MD
Capital Gastroenterology Consultants
3410 Olandwood Ct, Suite 206
301.593.2002

ROCKVILLE, MD
Associates in Gastroenterology
9420 Key West Avenue, Suite 202
301.251.9555

Birns, Gloger, Witten & Bhinder, MD
9711 Medical Center Dr, Suite 308
301.251.1244

Capital Gastroenterology Consultants
15005 Shady Grove Rd, Suite 350
301.593.2002

Digestive Disease Consultants
14955 Shady Grove Rd, Suite 150
301.340.3252

SILVER SPRING, MD
Capital Gastroenterology Consultants
10801 Lockwood Dr, Suite 200
301.593.2002

TAKOMA PARK, MD
Maryland Digestive Disease Center
7610 Carroll Ave, Suite 250
301.270.3640

PATHOLOGY LABORATORY

BOWIE, MD
4831 Telsa Dr, Suite F
240.737.0080

CLINICAL RESEARCH

CHEVY CHASE, MD
Chevy Chase Clinical Research
5550 Friendship Blvd, Suite T-90
301.652.5520