CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Dear New Patient:

Welcome and thank you for choosing Capital Digestive Care!

The enclosed packet contains important information for your upcoming appointment as well as our new patient registration forms. To be prepared for your appointment, please review this information carefully and bring the requested information with you on the day of your appointment.

It is very important to bring the following to your first visit:

√ Completed Patient Information Forms, Patient History Forms & Signed Notice of Privacy Practices (enclosed in this packet)

√ Insurance Card(s) and Insurance Referral, if applicable

√ Picture Identification (such as a driver's license)

√ Any recent Laboratory (blood work) results related to your visit with us

√ Any recent Radiology results related to your visit with us (e.g. Upper GI Testing, Barium Enema, CT scan or Ultrasound results)

√ A list of your current medications with dosage and frequency taken

√ For patients enrolled in HMO plans, a 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.

If you have been referred due to an abnormal laboratory/radiology result, it is imperative that we have a copy of these results so that we can complete your consultation without having to repeat testing.

Providing the above information on the day of your appointment will allow us to serve you in the most prompt, accurate and efficient manner.

Thank you for allowing us to participate in your medical care.

We look forward to seeing you soon.

* Capital Digestive Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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Patient Demographics

Patient Last Name:	Patient First Name:	Patient MI:
Patient Address:	Preferred Name:	SSN:
City:	Gender:	Date of Birth:
State, Zip code		Age:
Occupation:	Home Phone:	Work Phone:
Marital Status:	Cell Phone:	Email address:
Guarantor:	Phone:	Circle: Home / Cell / Work
Emergency Contact:	Phone:	Circle: Home / Cell / Work
Referring Physician:	Legal Representative if Patient is a Minor or for other reasons necessary:	
Primary Care Physician:	Preferred Language:	

Primary Insurance Coverage:

Carrier:	Policy ID #:
Carrier Phone:	Group ID / Name:
Claims Address:	Plan ID / Name:
City, State, Zip code:	Subscriber DOB:
Subscriber Name:	Patient Relationship to Subscriber:
Subscriber Gender:	Subscriber Employer:

Secondary Insurance Coverage:

Carrier:	Policy ID #:
Carrier Phone:	Group ID / Name:
Claims Address:	Plan ID / Name:
City, State, Zip code:	Subscriber DOB:
Subscriber Name:	Patient Relationship to Subscriber:
Subscriber Gender:	Subscriber Employer:

The above information is true and correct. I understand that I am financially responsible for any balances not covered by my insurance. I will pay those balances due within 20 days of receipt of a statement. If collections become necessary, I will be responsible for any cost incurred.

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 Capital Digestive Care 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.

Capital Digestive Care affiliated organizations:

Physician Billing	**Facility Billing** *(one of the following)*	**Anesthesia Billing** *(one of the following)*	**Pathology Billing**
CAPITAL DIGESTIVE CARE, LLC	AMBULATORY ENDOSCOPY CENTER OF MARYLAND	CORRIDOR ANESTHESIA, LLC	CAPITAL DIGESTIVE CARE PATHOLOGY LABORATORY, LLC
	BETHESDA ENDOSCOPY CENTER CHEVY CHASE ENDOSCOPY CENTER ENDOSCOPY CENTER OF WASHINGTON, D.C. ENDOSCOPIC SURGICAL CENTRE OF MARYLAND ENDOSCOPIC SURGICAL CENTRE OF MARYLAND – NORTH	CAPITAL ANESTHESIA PARTNERS, LLC	
	GASTROINTESTINAL ENDOSCOPY ASSOCIATES, LLC (GIEA)	MONTGOMERY ANESTHESIA CARE, LLC	
	URBANA GI ENDOSCOPY CENTER	MARKED ANESTHESIA, LLC MARYLAND ANESTHESIA PARTNERS (MAP) MARCOS FALTAMO, CRNA PC	

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.

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.

_____ _____

Signature of Patient or Representative | Date

_____ _____

Patient Name (Printed) | Date of Birth

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Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Capital Digestive Care is dedicated to maintaining the privacy of your protected health information. Federal and state laws ensure the privacy of your medical records, their availability to you, and specific rights regarding your medical records. In addition to your authorization, we may use or disclose your health information in accordance with the law under certain circumstances. Please refer to our full HIPAA Notice of Privacy Practices for all potential general use and disclosures.

I UNDERSTAND MY RIGHTS TO:

Revoke or change the authorization below at any time. (Please note, revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the notice to revoke). I may also inspect or copy my protected health information to be disclosed as described in this document. I understand that if the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

DISCLOSURE AND RELEASE OF PAPER OR ELECTRONIC RECORDS: (Choose and initial only **one** option)

_____ I **DO NOT** authorize the disclosure or release of my protected health information to any person/entity or via a
Initial message left on a voicemail.

_____ I authorize the physicians and staff of the practice to disclose health information regarding appointments, labs
Initial bills or other general patient communication via voicemail on the following telephone numbers:

Telephone #: _____ Telephone #: _____

_____ I authorize the disclosure or release of the following protected health information:
Initial

- All records
- Office visit notes
- Pathology Reports
- Radiology Reports
- Laboratory Reports
- Other (specify): _____

This information may be disclosed or released to: Name: _____
Relationship: _____ Address: _____
_____

This authorization expires on: ____/_____/_____ *(if no date specified, an automatic expiration occurs in one year)*.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name/Title of Representative

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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**: You will receive an email which includes a pin number that you will need to create your patient portal. You will then 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.
- **Appointment Reminders**: You may receive information regarding a scheduled or missed appointment via email, home phone, mobile phone or text messaging.
- **Patient Education**: You may receive video applications intended to provide necessary information regarding a scheduled procedure. You may also receive information on new treatments or clinical research trials, notification of educational seminars on specific digestive health topics or other relevant information.
- **Customer Service Improvements**: We are always evaluating applications to improve our service to you. As applications become available, you may receive a notification or registration invitation.
- **Chesapeake Regional Information System for our Patients (CRISP):** We have chosen to participate in a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.
- **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): _____Date of Birth: _____

Signature of Patient or Representative: _____ Date: _____