Dear Patient:

Thank you for inquiring about scheduling a colonoscopy with Capital Digestive Care. We have developed a protocol to schedule a colonoscopy for relatively healthy patients without an initial pre-procedure consultation. The first part of that protocol requires that you completely fill out the enclosed Personal Information, Insurance and General Authorization for Treatment form and the enclosed Comprehensive Medical History forms and return them to our office. After receiving all of the completed forms back at our office, we will review them and then contact you about scheduling your colonoscopy. After scheduling your colonoscopy, we will send you specific instructions on how to prepare and cleanse your colon prior to your procedure as well as other general instructions.

***BE SURE TO REVIEW BOTH FRONT AND BACK OF PACKET***

It is vitally important that you fill out the Comprehensive Medical History forms as completely as possible. We strive to make your procedural experience as pleasant and safe as possible. In order to give you the appropriate pre-procedural instructions we need to review your entire medical history.

Please pay special attention to filling out the dosages and frequencies of all of your medications. In addition, please make sure you fill out the allergy section completely.

There are some informational pamphlets enclosed regarding our practice and the colonoscopy procedure.

Please return the enclosed forms to our Laurel office as soon as possible so we can facilitate the scheduling of your colonoscopy.

If you wish to have an acknowledgement of our office receiving your screening colonoscopy packet, please address and stamp the enclosed postcard and return it with your packet. After we receive your packet of information and have sent back your postcard, we will review the medical history that you provided us. You will receive a call to schedule your colonoscopy at a convenient time for both you and the physician.

If you should need to reschedule your colonoscopy we ask that you notify us as soon as possible. There is a fee of $150.00 for procedures not canceled within 48 hours.

If you have any questions, or if you need any clarifications regarding the information above, please call us at 301-498-5500 during normal business hours 8:30AM to 5:00 PM.

Sincerely,

Jeffrey S. Garbis, M.D. Richard M. Chasen, M.D. Jeffrey Bernstein, M.D. Theodore Y. Kang, M.D.
Marvin E. Lawrence II, M.D. Sean M. Karp, M.D. Priti Bijpuria, M.D. 03/10/16 gg
### PATIENT INFORMATION

Date: ______________________

**Patient Information:**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Patient Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Address:</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Work Phone:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Sex: M F</td>
</tr>
<tr>
<td>Height:</td>
<td>Weight:</td>
</tr>
<tr>
<td>Age:</td>
<td>Marital Status: Single Married Other</td>
</tr>
<tr>
<td>Social Security #:</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Patient Employer:</td>
<td>Occupation:</td>
</tr>
</tbody>
</table>

**Spouse’s Information**

<table>
<thead>
<tr>
<th>Spouse’s Name:</th>
<th>Spouse’s Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse’s Social Security #:</td>
<td>Spouse’s Employer:</td>
</tr>
<tr>
<td>Spouse’s Work Phone:</td>
<td>Spouse’s Cell Phone:</td>
</tr>
</tbody>
</table>

**Emergency Contact Information:**

- Emergency Contact Name and Number:

**Physician Information:**

<table>
<thead>
<tr>
<th>Primary Care Physician:</th>
<th>Referring Physician:</th>
</tr>
</thead>
</table>
Primary Insurance:

<table>
<thead>
<tr>
<th>Insurance Co. Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Name of Policy Holder</td>
<td>Social Security #</td>
</tr>
<tr>
<td>Relationship to pt</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Insurance ID #</td>
<td>Insurance Group #</td>
</tr>
</tbody>
</table>

Secondary Insurance:

<table>
<thead>
<tr>
<th>Insurance Co. Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Name of Policy Holder</td>
<td>Social Security #</td>
</tr>
<tr>
<td>Relationship to pt</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Insurance ID #</td>
<td>Insurance Group #</td>
</tr>
</tbody>
</table>

***TO BE COMPLETED IF PATIENT IS A MINOR***

<table>
<thead>
<tr>
<th>Responsible Party</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Employer</td>
<td>Work Phone</td>
</tr>
</tbody>
</table>

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 and 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) ______________________ (revised 03-10-16 gg)

Patient Signature ______________________ Date: ______________________

Insurance Co. Name:

Insurance ID #:

Insurance Group #:

Phone #:

City, State, Zip:

Name of Policy Holder:

Social Security #:

Relationship to pt:

Date of Birth:

Insurance Co. Name:

Insurance ID #:

Insurance Group #:

Phone #:

City, State, Zip:

Name of Policy Holder:

Social Security #:

Relationship to pt:

Date of Birth:

Insurance Co. Name:

Insurance ID #:

Insurance Group #:

Phone #:

City, State, Zip:

Name of Policy Holder:

Social Security #:

Relationship to pt:

Date of Birth:
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!

○ Reason for visit

Race

○ White/Caucasian
○ Black or African American
○ Asian
○ Hispanic or Latino

○ American Indian or Alaska Native
○ Native Hawaiian or Other Pacific Islander
○ Mixed
○ Other

○ Unknown
○ Patient Declines to provide information

Ethnicity

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

Gender

○ Male
○ Female
○ Other

Preferred Language

○ English
○ Spanish
○ Other ________________________________

Contact Preference

○ Letter
○ Other ________________________________

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

Pharmacy: ________________________________

Allergies

○ Patient has no known allergies
○ Patient has no known DRUG allergies
○ Adhesive tape
○ Codeine Sulfate

○ Erythromycin
○ Latex
○ IV Contrast
○ Penicillins

○ Sulfa
○ Shellfish
○ Other
○ Other
Complete Patient History Form

Name: _____________________________ Date of Birth: _____________________________

**Current Medications** (include any Over-the-counter medications and any supplements you are currently taking)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>How taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**Immunizations**

<table>
<thead>
<tr>
<th></th>
<th>Flu vaccine</th>
<th>Hepatitis A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When:</td>
<td>When:</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Pneumovax</th>
<th>TB Skin test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When:</td>
<td>When:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diagnostic Studies**

<table>
<thead>
<tr>
<th></th>
<th>Colonoscopy</th>
<th>Endoscopy/EGD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When:</td>
<td>When:</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT Scan Abdomen/Pelvis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>MRI of Abdomen/Pelvis</th>
<th>ERCP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>When:</td>
<td>When:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Previous Procedures/Surgeries**

<table>
<thead>
<tr>
<th></th>
<th>Gallbladder removed</th>
<th>Appendectomy</th>
<th>Colon resection</th>
<th>Small Bowel resection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploratory Abdominal Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gastric Bypass Surgery</td>
<td>Lap Band Surgery</td>
<td>Hemorrhoid Surgery</td>
<td>Hemorrhoid Banding</td>
</tr>
<tr>
<td></td>
<td>Hysterectomy</td>
<td>Tubal Ligation</td>
<td>Mastectomy</td>
<td>Pacemaker Placement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Defibrillator Placement</th>
<th>Coronary Artery Bypass Graphing (CABG)</th>
<th>Aortic Aneurysm (AAA) Repair</th>
<th>Heart Valve Replacement /Surgery</th>
<th>Cardiac Catheterization /Stent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Replacement</td>
<td>Back Surgery</td>
<td>Other</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
Complete Patient History Form

Name: ___________________________ Date of Birth: ___________________________

**Past or Present Medical History**

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

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

- **Pulmonary**
  - C.O.P.D.
  - Asthma
  - Sleep Apnea
  - Blood Clots (leg)
  - Blood Clots (lung)

- **Other**
  - Anxiety Disorder
  - Arthritis
  - Bipolar Disorder
  - Body Piercings
  - Breast Cancer
  - Current Pregnancy
  - Depression
  - Diabetes
  - Fibromyalgia
  - Gout
  - HIV Exposure
  - HIV Infection
  - Hypothyroidism
  - Kidney Disease
  - Kidney Stones
  - Lung Cancer
  - Ovarian Cancer
  - Other Cancer
  - Prostate Cancer
  - Recurrent Infections
  - Seizures
  - Skin Cancer
  - Tattoos
  - Other
Complete Patient History Form

Name: _______________________________ Date of Birth: ____________________

**Social History**

<table>
<thead>
<tr>
<th></th>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Separated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Widowed</td>
<td>Civil Union</td>
<td>Unknown</td>
<td>Other</td>
</tr>
</tbody>
</table>

**I drink alcohol:**
- None
- Less than 7 per week
- More than 7 per week

**I drink caffeine:**
- (coffee, tea, cola, or other caffeinated drinks)
  - None
  - Occasionally
  - Daily

**I use tobacco:**
- (Circle) Cigarettes Cigars
- Chewing tobacco
- Every Day
- Only some days
- Former smoker
- Never smoked
- Smoker, Current status unknown
- Unknown if ever smoked

**My drug use:**
- None
- IV or inter-nasal drugs currently
- IV or inter-nasal drugs in the past

**I exercise:**
- None
- I exercise routinely

**Family History**

- No knowledge of family history

- **No one in my family has a history of:**
  - Celiac Sprue
  - Colon polyps
  - Gallbladder Disease
  - Liver Disease
  - Stomach Cancer
  - Colon Cancer
  - Inflammatory Bowel Disease
  - Polyps
  - Ulcerative Colitis

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

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
<th>Grandmother</th>
<th>Grandfather</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon Polyps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crohn's Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallbladder Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcerative Colitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Complete Patient History Form

Name: ____________________________ Date of Birth: ____________

Review of Systems. **What are your current symptoms today?** Check all that apply:

<table>
<thead>
<tr>
<th>Allergic/Immunologic</th>
<th>Gastrointestinal</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>allergic reactions</td>
<td>abdominal pain</td>
<td>back pain</td>
</tr>
<tr>
<td>current infections</td>
<td>abdominal swelling</td>
<td>joint pain/arthritis</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>change in bowel habits</td>
<td></td>
</tr>
<tr>
<td>chest pain</td>
<td>constipation</td>
<td></td>
</tr>
<tr>
<td>irregular heart beat</td>
<td>diarrhea</td>
<td></td>
</tr>
<tr>
<td>rapid heart rate/palpitations</td>
<td>gas</td>
<td></td>
</tr>
<tr>
<td>ankle swelling</td>
<td>heartburn</td>
<td></td>
</tr>
<tr>
<td><strong>Constitutional</strong></td>
<td>nausea</td>
<td></td>
</tr>
<tr>
<td>fever</td>
<td>rectal bleeding</td>
<td></td>
</tr>
<tr>
<td>loss of appetite</td>
<td>stomach cramps</td>
<td></td>
</tr>
<tr>
<td>weight loss</td>
<td>vomiting</td>
<td></td>
</tr>
<tr>
<td><strong>ENT</strong></td>
<td>difficulty swallowing</td>
<td></td>
</tr>
<tr>
<td>nose bleeds</td>
<td>yellowing of skin</td>
<td></td>
</tr>
<tr>
<td>loss of vision</td>
<td><strong>Genitourinary</strong></td>
<td></td>
</tr>
<tr>
<td>hoarseness</td>
<td>blood in urine</td>
<td></td>
</tr>
<tr>
<td>mouth sores</td>
<td>recent darkening of urine</td>
<td></td>
</tr>
<tr>
<td><strong>Endocrine</strong></td>
<td><strong>Hematologic/Lymphatic</strong></td>
<td></td>
</tr>
<tr>
<td>excessive thirst</td>
<td>easy bruising</td>
<td></td>
</tr>
<tr>
<td>heat or cold intolerance</td>
<td>anemia</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Integumentary</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>itching</td>
<td></td>
</tr>
<tr>
<td></td>
<td>rashes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>rashes/hives</td>
<td></td>
</tr>
</tbody>
</table>

**Neurological**
- dizziness
- fainting
- frequent headaches
- vertigo
- memory loss/confusion

**Psychiatric**
- depression
- anxiety/panic attacks

**Respiratory**
- wheezing
- frequent cough
- shortness of breath when at rest
NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully.

<table>
<thead>
<tr>
<th>Patient Health Information</th>
<th>Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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. Your information may be stored electronically and if so is subject to electronic disclosure.</td>
<td></td>
</tr>
<tr>
<td>How We Use &amp; Disclose Your Patient Health Information</td>
<td>Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.</td>
</tr>
<tr>
<td>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 information in your 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 family members who are helping with your care.</td>
<td></td>
</tr>
<tr>
<td>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 or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.</td>
<td></td>
</tr>
<tr>
<td>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, arranging for legal services and to assess the care and outcomes of your case and others like it.</td>
<td></td>
</tr>
</tbody>
</table>

Special Uses and Disclosures

Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures

We may be required or permitted to use or disclose the information even without your permission as described below:

- **Required by law:** We may be required by law to disclose your information, such as 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:** We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- **Health oversight:** We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Individual Rights

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

- You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full for the item or service covered by the request and when the uses or disclosures are not required by law.
- You may request that we not disclose your identifiable health information to a family member or friend who is helping with your care.
- You may request that your information not be disclosed in response to an subpoena, discovery request, or other legal process. We are not required to agree to a request.
- You have the right to request that we amend your health information. An amendment is a correction or other change to your health information. You must request an amendment in writing. Your request must include a clear explanation of why you believe the information should be changed.
- You have the right to receive an accounting of disclosures we make of your health information except for disclosures we are required to make by law or for certain uses and disclosures we make without your authorization. You must request an accounting in writing. Your request must include a time period.

Complaints

If you are concerned that we have violated your privacy rights, 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:

Center Leader

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: __________________________
There’s a new way to communicate with your doctor and their office.

In addition to calling us during regular business hours, we now have an online patient portal that allows you 24/7 access from anywhere.

gPortal will allow you to

- Send messages to your doctor or their staff (all messages left will be processed the next business day)
- Request appointments
- Check your laboratory results
- Request prescription refills
- Update your personal and medical records

If you are interested in signing up for our gPortal, please complete the information below and an invitation will be emailed to you. Your emailed invitation will be titled “Myportal-no reply with Capital Digestive Care in the subject.” Be sure to check your spam and junk email for the invitation. If you don’t receive your invitation within a couple days let us know and we’ll resend it.

Name: __________________________________________________________

Date of Birth: _____________________________________________________

Email Address: ____________________________________________________

Date: ____________________________________________________________

Be sure to ask a staff member for a gPortal brochure. We look forward to communicating with you online.

03-10-16 gg
DIRECTIONS TO AMBULATORY ENDOSCOPY CENTER OF MARYLAND:

Laurel Office:
Laurel Medical Arts Pavilion
7350 Van Dusen Rd.
Suite 230
Laurel, MD 20707
Telephone: 301-498-5500
Fax: 301-498-7346
Business Office: Suite 250

From the South:
• Take I-95 North toward Baltimore
• Take exit 33A, which is Laurel Route 198.
• As you exit off ramp, stay in your far right lane.
• At intersection make right turn onto Van Dusen Road.
• Stay straight on Van Dusen.
• At 5th traffic light turn right into Laurel Regional Hospital’s driveway. Our building sits to the right of the hospital.
Recommended for Internet Explorer (8 or higher), or Mozilla-Firefox.

Create your username and password today!

Start taking an active role in your healthcare!

Contact...

Capital Digestive Care
First in Digestive Health

Maryland Digestive Disease Center
Laurel, MD
Columbia, MD
Takoma Park, MD
301-498-5500

How to Start...

Introducing...

Now we have an interactive online portal designed specifically for you, our valued patient.
**How do I register?**

**Step 1:** You will receive an invitation email from our practice with a link and unique ID that will take you through the registration process.

**Step 2:** Click on the link in the invitation email to create a unique user ID and password.

**Step 3:** Once registered, complete your medical, family and social history.

**Step 4:** Click submit to send your information directly to our office.

**Send a message to my Doctor’s office?**
- Click on the message tab.
- Click “new” and compose your message.
- Remember to hit send.

**Receive messages through gPortal?**
- You will receive a notification email when you have a message waiting in gPortal.
- Click on the message tab.
- Click on “new messages” to view your messages.

**Update my personal information?**
- Click “update” button.
- Click on the “personal info” tab.
- Change the information you want.

**Frequently Asked Questions**

Q: Can I schedule my appointment online through gPortal?
A: You may send a request to schedule your appointment and our practice will contact you.

Q: Does gPortal allow me to send a message directly to my physicians office?
A: Yes, you may send a message directly to our office through gPortal. We will make sure your message reaches the correct person so that your question is answered.

Q: Can I refill my prescriptions through gPortal?
A: No, you must go directly through your pharmacy in order to refill your prescription.

Q: What do I do if my account is locked due to too many failed log-in attempts?
A: Click on the change password tab and follow the instructions to create a new password.
If you need a translation:

- To assure there are no children left unattended in the
  - responsible at all.
- To be aware of the potential for
  - Transaction into the facility by a
  - Patterns are responsible for藝挼
  - and property.
- For showing respect and consideration to other people
  - does not complies this requirement.
- For the disposition of their vehicles at the Center
  - Center as soon as possible.
  - will notify the
  - counterfeit and keep a record of
  - counterfeited are paid in a timely manner.
- For their actions they should receive a reward of
  - counterfeit is POSSIBLE.
  - to follow the recommendation in this case.
- To acknowledge the power of the
  - should be recognized for
  - communications regarding the care of health.
- To assure of the confidentiality of health
  - without compromising the patient’s privacy.
- To be informed of any request for
  - to comply with the guidance without fear of
  - to be aware of fees for service and the billing process.
- To receive treatment without discrimination as to race,
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  - to receive treatment without discrimination as to race,
  - to receive treatment without discrimination as to race,
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  - to receive treatment without discrimination as to race,
Report to Suite 203. Medical Arts Pavilion is on the right. Regional Hospital's driveway. Turn right on Van Deusen Road. At this
Take L-95 to exit 33A, Route 198 - Lantel
Endoscopy Center of Maryland
Directions to the Ambulatory
Contacts
Links to Digestive Resources
Digestive Disorders
Procedures Performed
Medical Staff Profiles
For Information on: www.cjbenedicthealthcenter.com
We encourage you to visit us on the web at
 To perform with dignity, excellence and compassion.
 To be responsible, ethical, and accountable.
 To build strong partnerships to improve the health of our community.
 To continuously improve the quality and outcomes of our care.
 To be patient-centered and partner with patients and families in making decisions.
 To embrace diversity and inclusiveness.
 To engage in continuous learning and development.
 To be accountable to the community we serve.
Patient Billing Explanation

Dear Patient:

You are scheduled to have an endoscopic procedure at Ambulatory Endoscopy Center of Maryland. The procedure will be performed by one of the Capital Digestive Care GI physicians. During the procedure you may receive sedation administered by one of the Anesthesia Group CRNA's (Certified Registered Nurse Anesthesiologists).

Frequently during the endoscopy your doctor will take a biopsy(s). If a biopsy is obtained, the specimen will be processed at the Capital Digestive Care Pathology Lab and will be interpreted by one of their pathologists.

Your procedure will generate the following different charges to your insurance or to you, if you do not have insurance:

**Professional Fee:** This is the fee from the Capital Digestive Care, LLC, GI physician that performed your procedure.

**Facility Fee:** This is the fee from Ambulatory Endoscopy Center of Maryland where your procedure is going to be performed.

**Anesthesia Fee:** This is the fee from Corridor Anesthesia, LLC for the services provided by the CRNA.

**Pathology Fee:** This is the fee from Capital Digestive Care Pathology for the interpretation of the biopsy by one of the pathologists.

If you have any questions prior to your procedure about the fees generated by any of the groups, please call Ambulatory Endoscopy Center of Maryland at 301-498-5500.

Your explanation of benefits (EOB) can be confusing. The following information may help you to understand this document:

**Total Charges:** This is the total amount billed to insurance. This charge will be processed by the payer according to its contract with the facility.

**Allowed Amount:** This is the total amount the facility expects to receive from insurance and/or patient combined. (It is also called the negotiated amount or expected amount).

**Payable amount:** This is the amount that the primary insurance will pay.

**Patient responsibility:** This is the difference between the allowed amount and the payable amount. This represents any deductibles and co-payments or co-insurance. If you have a secondary insurance they may pay for all or part of the “patient responsibility”, depending on your contract.

3-10-16 gg