



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.



Patient Information

Patient Last Name:	Patient First Name:	Patient MI:
Patient Address:	Preferred Name:	
City:	Gender:	Date of Birth:
State, Zip Code:	Home Phone:	Cell Phone:
Email address:		
Emergency Contact:	Phone:	Circle: Home / Cell / Work
Referring Physician:	Legal Representative if Patient is a Minor or for other reasons necessary:	
Primary Care/Referring 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: M <input type="checkbox"/> F <input type="checkbox"/>	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: _____



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:

<u>Physician Billing</u>	<u>Facility Billing</u> <i>(one of the following)</i>	<u>Anesthesia Billing</u> <i>(one of the following)</i>	<u>Laboratory Billing</u> Pathology & Clinical Laboratory
CAPITAL DIGESTIVE CARE, LLC	AMBULATORY ENDOSCOPY CENTER OF MARYLAND BETHESDA ENDOSCOPY CENTER CHEVY CHASE ENDOSCOPY CENTER ENDOSCOPY CENTER OF WASHINGTON, D.C. ENDOSCOPIC SURGICAL CENTRE OF MARYLAND ENDOSCOPIC SURGICAL CENTRE OF MARYLAND – NORTH FALLSGROVE ENDOSCOPY CENTER GASTROINTESTINAL ENDOSCOPY ASSOCIATES, LLC (GIEA) SOUTHERN MARYLAND ENDOSCOPY CENTER URBANA GI ENDOSCOPY CENTER	CAPITAL ANESTHESIA PARTNERS, LLC CORRIDOR ANESTHESIA, LLC MARYLAND ANESTHESIA PARTNERS (MAP) MONTGOMERY ANESTHESIA CARE, LLC POTOMAC ANESTHESIA CONSULTANTS	CAPITAL DIGESTIVE CARE, LLC

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.
4. I understand my provider may order laboratory diagnostic tests to be performed by Capital Digestive Care’s Laboratory. I understand that that my insurance carrier may or may not provide coverage for laboratory studies and that these rules are carrier specific. By proceeding with the diagnostic testing ordered by my provider, I acknowledge I am financially responsible for all charges not paid by my insurance company, including any deductibles, copays, co-insurance, and any charges or services deemed not covered by my insurance.

Signature of Patient or Representative

Date

Patient Name (Printed)

Date of Birth



Authorization to Release Medical Information

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



COMMUNICATIONS NOTIFICATION

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 that contains a pin number which you will need to create your Patient Portal. When you create your portal, 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.
- **Appointment Reminders:** These may include information regarding a scheduled or missed appointment via email, home phone, mobile phone or text messaging.
- **Patient Education:** These may include video applications intended to provide necessary information regarding a scheduled procedure. Capital Digestive Care will send information regarding 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, 10770 Columbia Pike, Suite 400, Silver Spring, MD 20901.

Patient Name (please print): _____ **Date of Birth:** _____

Signature of Patient or Representative: _____ **Date:** _____

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 upon request.

Patient Health Information

Under federal law, 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.

Examples 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.

We participate in Chesapeake Regional Information Systems for our Patients (CRISP), 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. Refer to our Communications Notification form if you prefer to opt out of this program.

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 Privacy Officer at the location where you are receiving services to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosure 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.

Confidential Communication: You may ask us to communicate with you confidentially, for example, sending notices to a special address or not using postcards 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. An administrative fee may apply.

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 of 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 operations.

Breach Notification: We are required to notify you in the event of a breach or inadvertent disclosure of your protected health information and will do so accordingly.

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. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the Privacy Officer at the location where you are receiving services.

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 Privacy Officer at the location where you are receiving services. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Capital Digestive Care
ATTN: Privacy Officer
10770 Columbia Pike, Suite 400
Silver Spring, MD 20901
Contact us on the website at CapitalDigestiveCare.com or send an email to PatientRelations@capitaldigestivecare.com

I _____ (Print Name)
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: _____

Date: _____