



CAROLINA DIGESTIVE HEALTH ASSOCIATES, PA

Welcome from Carolina Digestive Health Associates, P.A.

Our goal is to provide you with the utmost professional experience while fulfilling all of your health-care requirements. We would appreciate your assistance with our registration process.

Please read this letter carefully and complete all included forms before your arrival for the office appointment. Do not mail your forms. Bring them with you.

- This appointment is for an office visit only.
- Please visit our website for practice information and specific office directions at www.CarolinaDigestive.com.
- You will receive an automated appointment reminder call 48 to 72 hours before your appointment. Please follow the prompts to confirm or cancel your appointment.
- If you are unable to attend your appointment, we expect a minimum of 48 hours notice. (Please extend this courtesy as other patients may need these time slots)
- *We charge a \$25.00 fee to patients that do not arrive for their appointment or do not provide adequate notice. There is also a \$100.00 fee for failure to show for a procedure or fail to provide adequate notice.*
- Please arrive 15 minutes early for your first appointment to allow for timely registration.
- Please bring your insurance card, Photo ID and be prepared to pay your co-pay for every visit.
- If you do not have an adult that may accompany you as a translator, please provide us 72-hour notice so that we may arrange one for you.
- If your insurance plan requires that you have a referral to see a specialist, we urge you to contact your PCP to confirm that one has been provided for you.
- All nursing home and assisted living residents should be accompanied by someone capable of caring for his or her needs throughout the office visit. Should a resident be dropped off at our facility without appropriate personnel for this level of care, the resident will be sent back to their facility and rescheduled to a later time and day.

CarolinaDigestive.com

Patient History Form

Name _____ Date of Birth _____ Age _____
Male Female Height _____ Weight _____
Who is your primary care provider? _____
Pharmacy _____ Phone # _____
(ONLY ONE PLEASE)

What is the main reason for your visit? (pick up to two)

<input type="checkbox"/> Colon Cancer Screening	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Fever	<input type="checkbox"/> Rash
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Confusion	<input type="checkbox"/> Flatulence (Gas)	<input type="checkbox"/> Rectal Bleeding
<input type="checkbox"/> Abdominal swelling	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heartburn/Reflux	<input type="checkbox"/> Speech Difficulty
<input type="checkbox"/> Anal itching	<input type="checkbox"/> Cough	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Tarry/Black Stool
<input type="checkbox"/> Anal/Rectal pain	<input type="checkbox"/> Depression	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Back pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Itching	<input type="checkbox"/> Weakness
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Difficult Swallowing	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Belching	<input type="checkbox"/> Edema	<input type="checkbox"/> Nausea	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Bloating	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Obesity	<input type="checkbox"/> Wheezing

Medical Problems (if yes)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Ulcer Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma/Bronchitis	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer type _____	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> History of colon polyps	<input type="checkbox"/> Reflux disease	<input type="checkbox"/> Defibrillator
<input type="checkbox"/> COPD/Emphysema			
<input type="checkbox"/> Other medical problems:			

Allergies and Reactions

Allergic to Latex? Y N

Please list all Allergies and Reactions (Medications, foods and Environment):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Surgeries/Hospitalizations (and dates)

1. _____
2. _____
3. _____
4. _____

Have you ever had a flexible sigmoidoscopy? Y N

If Yes, please give the date _____

Have you ever had a colonoscopy? Y N

If Yes, please give the date _____

Have you ever had an upper endoscopy? Y N

If Yes, please give the date _____

Name _____

List your current medications and doses (including over the counter)

Please leave "Last Dose" column blank if you have a procedure. The nurse will assist you with this section.

1. _____	Dosage _____	Last Dose _____
2. _____	Dosage _____	Last Dose _____
3. _____	Dosage _____	Last Dose _____
4. _____	Dosage _____	Last Dose _____
5. _____	Dosage _____	Last Dose _____

If you need to add additional medication please ask front desk for an additional sheet of paper

PATIENT CURRENT REVIEW OF SYSTEMS

Constitutional

- Chills Y N
- Fever Y N
- Feeling Tired Y N
- Recent Weight Gain Y N
- Recent Weight Loss Y N
- Pregnant Y N

Eyes

- Blurred Vision Y N
- Glaucoma Y N
- Contacts or Glasses Y N

Ears/Nose/Mouth/Throat

- Hearing Aid Y N
- Hoarseness Y N
- Nose Bleeds Y N
- Sinus Problems Y N
- Sore Throat Y N

Cardiovascular

- Chest Pain Y N
- Irregular Heart Beats Y N
- Shortness of Breath Y N
- Swelling of Ankles Y N
- Pacemaker Y N
- Defibrillator Y N
- Stents Y N

Neurological

- Brain/Spinal Injury Y N
- Confused Y N
- Fainting Y N
- Headaches Y N

Gastrointestinal (Symptoms within the past year)

- Abdominal Pain Y N
- Abdominal Swelling Y N
- Anal Itching Y N
- Anal Pain/Sore Y N
- Appetite Loss Y N
- Belching Y N
- Bloating Y N
- Constipation Y N
- Change in bowel habit Y N
- Diarrhea Y N
- Difficulty Swallowing Y N
- Get full easily Y N
- Heartburn/Reflux Y N
- Incontinence of Stool Y N
- Nausea Y N
- Pain on Swallowing Y N
- Pain when Defecating Y N
- Vomiting Y N

GI Bleeding

- Black / Tarry Stool Y N
- Maroon Stool Y N
- Rectal Bleeding Y N
- Vomiting Blood Y N
- Vomiting Y N
- 'Coffee Grounds' Y N

Airway

- Sleep Apnea Y N
- Use C-PAP Y N
- Difficulty Opening Mouth Y N
- Difficulty Turning Y N

Respiratory

- Chronic Cough Y N
- Wheezing Y N
- Positive TB Skin Test Y N
- Use Oxygen @ Home Y N

Genitourinary

- Blood in Urine Y N
- Frequent Urination Y N
- Incontinence Y N

Musculoskeletal

- Back Pain Y N
- Joint Pain Y N
- Joint Replacements Y N
- Joint Swelling Y N
- Muscle Pain Y N

Psychiatric

- Anxiety Y N
- Depression Y N

Integumentary (Skin)

- Itching Y N
- Rash Y N
- Skin Ulcers Y N

Hematological

- Anemia Y N
- Easy Bleeding / Bruising Y N
- Past Blood Transfusion Y N

Weakness/Numbness Y N Head

Name _____
Y N

Immunizations and vaccinations

Have you ever had a Pneumonia Vaccination? Y N If Yes, please give the date _____
Have you had an Influenza Vaccination in the last year? Y N If Yes, please give the date _____

Social history and habits

Married? Y N Current occupation _____
Children? Y N Ages _____
Do you smoke or chew tobacco? Y N How Much? _____
Do you drink alcohol? Y N How much and how often? _____
Have you ever used street drugs or recreational drugs? _____

Family history

Father: Age _____ Living – Illness _____ Deceased – Cause of Death _____
Mother: Age _____ Living – Illness _____ Deceased – Cause of Death _____
Brothers: Number _____ Any illnesses? _____
Sisters: Number _____ Any illnesses? _____

Have any of your close relatives (parents, grandparents, brothers, sisters, children) had: (if yes)

- | | | |
|--|--|---|
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Crohn’s disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Cancer type _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Colon cancer? Who _____ | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Colon polyps? Who _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Other diseases: | | |

Other Pertinent Information _____

Patient Signature: _____

Date: _____

If you are scheduled for a colonoscopy, flexible sigmoidoscopy or EGD, the information on this form must be updated within 30 days of having the procedure. (This update can be done on the day of the procedure.)

Please check one of the following boxes:
I have reviewed this form; there are: no changes changes
If changes, please list: _____

Patient Signature: _____ Date: _____

Form Reviewed by _____
Form Reviewed by _____

Date _____
Date _____



Patient Financial Responsibility Agreement

(Rev. 2/29/09)

In order for Carolina Digestive Health Associates P.A. to continue providing our patients with quality medical care, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our PATIENTS' RESPONSIBILITY.

As a patient of Carolina Digestive Health Associates, you are hereby agreeing:

- To Pay all non-insured charges, including your co-pay, co-insurance, insurance deductible, out-of network charge differential, and all other non-covered charges at the time of service or when otherwise advised.
***If this is not possible, you agree to contact our Business Office BEFORE services are rendered.
- To Provide us with a copy of your most recent insurance card or other Proof of insurance at the time of EACH service, including hospital-based services. If you do not provide us with valid insurance information at the time of EACH service, you agree to personally pay all unpaid charges.
- To Obtain any required authorization under your insurance plan for our services from your primary care physician and/or your insurer prior to each appointment. If you do not receive the required authorization, your insurer may not pay us for our services. In these cases, you agree to personally pay any resulting unpaid charges.
- ***To Monitor your insurance company's payment of your account and, if unpaid within 60 days from the date of service, to contact them regarding non-payment, and to cooperate with CDHA to resolve the unpaid status of your account.
- We charge a \$25.00 fee to patients that do not arrive for their appointment or do not provide adequate notice. We will also charge \$100.00 for failure to show for a procedure or not providing adequate notice.

Further, you agree that your physician and Carolina Digestive Health Associates P.A. has the right to be paid for their services and you acknowledge:

- That unpaid bills older than 90 days from date of service may be turned over to a debt collection agency or attorney for collection.
- That you will be responsible for any resulting collection fees, including reasonable attorney fees, and/or bank fees incurred as a result of a returned check.

Patient or Guarantor

Signature _____ Date _____

By my signature, I am indicating that I have read, understand and agree to the above provisions.

No form may be altered without express permission.



Registration Form

Please complete this form in full

Patient Information

Name (Last)	(First)	(Middle Initial)	Social Security #	Date of Birth
Race: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> S	<input type="checkbox"/> M	<input type="checkbox"/> D	<input type="checkbox"/> W
Address (Street)	(city)	(state)	(Zip Code)	Work Phone#
Primary Physician Name	Office Address	Office Telephone#		
Referring Physician Name if different	Patient E-Mail			
Pharmacy	Phone			

Insurance and Policy Holder Information

Primary Insurance Information

Insurance Company Name

Policy Holder Name

Date of Birth
Insurance ID

Insurance Group
#

Employer

Employer Street Address

Employer City, State, Zip Code

Employer Telephone #

Patient Relationship to Policy Holder

Secondary Insurance Information

Insurance Company Name

Policy Holder Name

Date of Birth
Insurance ID

Insurance Group
#

Employer

Employer Street Address

Employer City, State, Zip Code

Employer Telephone #

Patient Relationship to Policy Holder

Emergency Contact

Name	Phone Number	Relationship to Policy Holder
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I give permission to Carolina Digestive Health Associates, PA to treat me at each visit and suggest further treatments as they deem necessary. I give permission to release medical information necessary to my insurance company for payment of claims and assign benefits to Carolina Digestive Health Associates, PA. I understand I am financially responsible for charges not covered by these insurance carriers. Reminders for appointments and procedures may be sent by mail to remind me to call for scheduling. ***A voice mail message will be left on this number for appointment reminders.

Patient/Guarantor Signature: _____ Date: _____

For office use:	Date: _____	Intitals _____
Physician: _____	Account # _____	



REQUEST FOR RELEASE OF MEDICAL INFORMATION

To: (Facility Name) (Address or Fax Number)

Patient Name: DOB:

I authorize you to disclose the following information from the medical record of the above named patient to Carolina Digestive Health Associates at the address or fax number listed below. The purpose of this disclosure is to provide further medical treatment to the patient.

Specific information to be disclosed (please check appropriate items): All Records Office Visit Notes Operative Reports Test Results (Labs, X-rays, Etc.) Pathology Reports

Date(s) of Service to be disclosed: From To

This authorization will expire on the following date:

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in the document. I can do this by written notification to Carolina Digestive Health Associates, PA at one of the addresses listed below.

(Signature of Patient or Representative) (Date) (Relationship to Patient)

Do not complete below – CDHA Office Use Only

Please send records via Fax Mail to the attention of Dr. at the Carolina Digestive Health Associates office checked below:

- 300 Billingsley Rd., Ste. 200 Charlotte, NC 28211 704-372-7974 (Office) 704-372-4966 (Fax)
10370 Park Rd., Ste. 200 Charlotte, NC 28210 704-543-7305 (Office) 704-543-6392 (Fax)
1450 Matthews Township Pkwy., Ste. 460 Matthews, NC 28105 704-814-0779 (Office) 704-814-0789 (Fax)
1663 Campus Park Dr., Ste. D Monroe, NC 28112 704-291-2488 (Office) 704-291-7533 (Fax)
547 Highland St. Mt. Holly, NC 28120 704-820-9430 (Office) 704-820-9426 (Fax)
101 E. W.T. Harris Blvd., Ste. 3215A Charlotte, NC 28262 704-510-8933 (Office) 704-510-8883 (Fax)
101 E. W.T. Harris Blvd., Ste. 3111 Charlotte, NC 28262 704-547-8818 (Office) 704-547-9865 (Fax)
705 Griffith St., Ste. 205 Davidson, NC 28036 704-799-2750 (Office) 704-799-2760 (Fax)
4315 Physicians Blvd., Ste. 202 Harrisburg, NC 28075 704-455-9700 (Office) 704-455-6677 (Fax)
3614 Providence Rd. S., Ste. 100 Waxhaw, NC 28173 704-291-2488 (Office) 704-291-7533 (Fax)



ALTERNATIVE CONFIDENTIAL COMMUNICATIONS AND ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

Patient Name _____ Date of Birth _____

If we are unable to reach you, we will need an alternative method of communicating information to you. Check the box next to the method(s) you would like Carolina Digestive Health Associates to use to communicate personal health, treatment, or payment information to you. This is the most current request that supercedes all prior requests. You may update this request as needed.

E-mail: I recognize that email may not be secure, but I authorize you to email me anyway.

(E-mail address at which I wish to be contacted)

I authorize you to leave detailed information at the following number

Phone _____

Alternative Contact: _____
(name of person CDHA may contact when unable to reach me)

I understand that this contact person is permitted to receive detailed health information, such as test results.

Phone: _____

Address: _____

By signing below I authorize Carolina Digestive Health Associates to communicate protected health information to me as described above. I further acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for Carolina Digestive Health Associates describing how my protected health information may be used and disclosed as permitted under federal and state law. I understand that I may obtain a complete copy of the Notice for my records upon request at any time.

Signature

Date

For Office Use Only

We were unable to obtain a written acknowledgement of the Notice of Privacy Practices because:

An emergency existed and a signature was not possible at the time.

The individual refused to sign.

Unable to communicate with the patient for the following reason:

Other:

CDHA Employee _____ Date _____