DIGESTIVE DISEASE ASSOCIATES

PATIENT INFORMATION

First Name	M.I.	Last Name	Date of Birth	Age	Sex M F
Street Address		City		State	Zip Code
E-Mail Address		Primary Contact #		Secondary Contact #	
SSN	Marital Status	Single Married Divorced Widowed			

Current Employer

Employer Name and Address	Phone Ext.
Primary Insurance	Policy Holder ID#
Secondary Insurance	Policy Holder ID#

Guarantor Information

First Name	M.I.	Last Name	Date of Birth	Sex M F
Street Address	City State	Zip Code	Primary Contact #	Secondary Contact #
SSN		Employer		

Emergency Contact

First Name	M.I.	Last Name	Relationship to Patient	Sex M F
Street Address	City State	Zip Code	Primary Contact #	Secondary Contact #

Demographics

Please Circle Your Race	Black/African American Asian Hawaiian/Pacific Islander White Other
Please Circle your Ethnicity	Hispanic/Latino Not Hispanic/Latino Other
Preferred Language	

Preferred Pharmacy

Primary Pharmacy Name	Phone Number
Referring Physician	**Primary Care Physician**

Financial Responsibility and Assignment of Insurance Benefits: I guarantee payment to **Digestive Disease Associates** for all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical benefits, which would otherwise be payable to me, to **DDA.**

Consent for Release of Medical Information: I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Acknowledgement of Receipt of Joint Notice of Privacy Practices: I have received a copy of **DDA** Notice of Privacy Practices.

Signature of Patient or Authorized Person	Date	Time
Staff Signature	Date	Time

Medical History Update

_____

Date

_____

Patients Name (please print)

Reason for visit today: _____

Previous Surgeries:

_____

_____

_____

_____

Medication Allergies or Reactions: _____

Present Medications with dosage and instructions:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

Frequently Used Non-Prescription Medications:

Aspirin: _____ How much? _____

Laxatives: _____ How much/often?

_____

Social History:

Do you smoke? _____ How much? _____

Do you drink? _____ How much? _____

History of HIV+, Aids or Exposure to? _____

History of Tuberculosis, Positive Skin Test or Exposure to? _____

DIGESTIVE DISEASE ASSOCIATES OF YORK COUNTY, P.A.
STEPHEN J. BOTT, M.D.
RANDOLPH L. RODRIGUE, M.D.
LARRY H. PENNINGTON, M.D.
SCOTT C. RICHARDSON, M.D.
BRET M. GARRETSON, M.D.
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170 AMENDMENT AVE.
ROCK HILL, SC 29732

TELEPHONE 803-324-7607
FAX 803-324-4097

Please list the names of anyone that you are giving authorization to obtain your medical information. For example (spouse, family members, friends etc.)

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature **Date**

PLEASE READ CAREFULLY

DISCLOSURE/AGREEMENT

Date: _____

Patient's Name: _____

Date of Birth: _____

Reason for todays visit:

◯ **Routine Preventative Exam (I have no medical complaints or problems that I am aware of)**

You need to know rules from CMS guidelines are as follows:

If during the course of such screening colonoscopy, a polyp is detected which results in a biopsy or removal of the polyp, payment shall not be made for the screening colonoscopy but shall be made for the biopsy. Based on this language, in such instances the procedure is no longer classified as a "screening test". This also applies to any abnormal findings. If you insurance pays 100% for a screening benefit, you may not get this benefit, due to the polyp or abnormal findings.

◯ **I have a problem/complaint that I wish to have evaluated/treated by the doctor.**

My Chief Complaint is: _____

I agree and understand that this office can only code and file a claim for my visit with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from any insurance carrier is inappropriate and may result in fraud.

_____

Patient Signature(or responsible party if minor)

Digestive Disease Associates of York County, P.A.

Notice of Privacy Practices

Effective April 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Understanding your medical record/health information
As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examination, test results, diagnoses, treatments, correspondence with other providers and plans for future care of treatment.

Your health information rights
Your health records is the physical property of this practice, however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Office of the Practice of your requests for any of these actions:

A. You have the right to request that we amend your health information.
B. You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
C. You have the right to request restriction on the use of your information.
D. You have the right to receive a paper copy of this notice.
E. You have the right to request an account of certain disclosures of information that have been made about you. This listing includes disclosures of your information for others for treatment, payment of healthcare purposes and is within a specified period of six years. The first listing of disclosures is provided at no charge and a reasonable fee will be charges for any additional copies within a twelve-month period.
F. You have the right to request that you receive communications regarding your information in a certain manner or a certain location.
G. You have the right to revoke any authorizations for disclosure.

It is the responsibility of our practice to:

A. Maintain the confidentiality and protect the privacy of your health information.
B. We will make available to you a copy of notice explaining our legal duties and privacy practices.
C. We will abide by the terms of this notice.
D. We will notify you if we are unable to agree with a request to restrict information.
E. We will accommodate reasonable requests that you make in order to communicate health information by alternative means or at alternative locations. We reserve the right to change our privacy practices and will notify you of any changes as you return to our office.

Our office will disclose information for the following reasons:

We will disclose health information for treatment purposes, payment, and other healthcare operations.

Treatment:
We will disclose your health information for treatment purposes and will provide your other healthcare providers with copies of various reports that will help them in any treatment needs that may arise.

Payment:
We may send a copy of a bill for payment to you or any third party payers. We will also furnish third party payers with any information necessary in order to process payment. This information may include medical records, diagnosis, information identifying you etc.

Business Associates:
There are some services provided through contracts with business associates. When those services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associates must appropriately safeguard your information.

Notification:
We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.

Research:
We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain a written authorization from you to disclose information for other research purposes.

Funder Directors:
We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.

Organ Donation:
If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation procedures.

Marketing:
We may contact you to provide appointment reminders or information about health related benefits and services that may be of interest to you, and leave messages on your answering machines.

Fund raising:
We may contact you as a part of a fund-raising event.

Food and Drug Administration:
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable produce recalls repairs or replacement.

Workers compensation:
In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.

Public Health:
Under South Carolina law, we may disclose your health information to the health department in order to prevent or control disease injury or disability.

Health investigation:
Federal and state laws make provisions for your health information to be released appropriate health authorities provided that a member of our staff or business associates believes in good faith that we have engaged in lawful conduct or have otherwise endangered on or more patients, workers or the public.

Other disclosures:
Other uses and disclosures of your information will only be made with written authorization. I you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

Questions and Complaints:
If you would like more information about or privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, please contact our office.
803-324-7607