WE ARE HAPPY YOU SELECTED US

Welcome to Digestive Care Physicians. We are honored that you have chosen us for your Gastrointestinal needs. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

Your first visit will be with either one of our physicians or physician's assistant. If your referring physician sent you for a colonoscopy or EGD, these procedures will be scheduled ***AFTER*** your appointment with one of our providers.

You will need to bring your insurance card and a photo ID with you for each appointment. After your initial visit, please let our staff know if you have had any information changes since your last appointment. You will be asked to fill out new registration forms annually so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring any medical records with you including any lab results, procedure reports or radiologic reports. Please bring all of your prescription and over-the-counter medications with you at each visit.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Providing the highest quality of professional care to our patients is very important to us. We strive to answer all calls immediately; however, if you need to leave a message we will try and get back with you the same day of your message. If you need refills of medications, please contact the office with time since our staff must speak with your provider before any refills may be sent to your pharmacy.

If you need to reach the physician after hours, you can reach our answering service at (770) 227-2222 Our office hours for patient care are Monday thru Thursday 8:00 AM – 5:00 PM and Friday from 8:00 AM to 3:00 PM.

Welcome to our practice and thank you for choosing Digestive Care Physicians for your GI health care needs.

Sincerely,
Digestive Care Physicians

PATIENT CONTACT INFORMATION

***Last Name** _____ **First** _____ **MI** ___ Previous Name (if any):

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home phone _____ **Cell phone** _____ **Work Phone** _____

For automated appointment reminders, please advise the preferred # to use: (Circle one)

Home Cell Work **Also notify using:** □ Pt.Portal □ Txt Msg:

Preferred time to call: □ Morning □ Afternoon □ Evening

***Primary Care Physician:** _____ ***Who referred you here?** _____

Date of Birth _____ **Sex** _____ **Marital Status:** □ Married □ Single □ Divorced □ Widowed

Social Security # _____-_____-_____

Employer _____ **Emp Status:** F/T, Retired, Self-Employed, Unemployed, Student

Employer Address: _____ OK to leave msg at work? **Y / N**

Emergency Contact _____ Relation: _____ **Phone** _____

Person Responsible for the bill (circle one): Self Emergency Contact Other _____
If Other, Relation: _____

I do/ do not authorize Digestive Care Physicians, LLC to discuss my appointments, medical evaluation, treatment and results to relatives or other persons as indicated: _____

INSURANCE INFORMATION

***Primary Insurance** _____ Address_____
Phone _____ City, State, Zip _____
Policy# _____ Group#/Name _____
Policy Holder's Name and Date of Birth _____
Pre-Certification required for IN patient or OUT patient services? □ No □ Yes: phone _____

***Secondary Insurance** _____ Address _____
Phone _____ City, State, Zip _____
Policy# _____ Group#/Name _____
Policy Holder's Name and Date of Birth _____
Pre-Certification required for IN patient or OUT patient services? □ No □ Yes: phone _____

OTHER INFORMATION

*I give permission to DCP to release my medical data to bill the insurance. _____ **(initial)**

*I give permission to DCP to access my prescription history from external sources _____ **(initial)**

*I have Advance directives/Living will that I would like to keep on file: Y / N

□ Check here if you do not want a billing statement sent to your mailing address.
(You will still be able to access it on your patient portal)

Physical Address (if different from mailing address): _____

E-mail address (required) _____

***Race/Ethnicity**: □ American Indian/Alaska Native □ Asian □ Native Hawaiian □ Hispanic □ White/Caucasian □ Black/African American □ Other Pacific Islander □ Other

*Language if other than English? _____

Preferred Lab company (if any): *LabCorp* *Quest* *Other:* _____
*Your insurance may have specific requirements.

Pharmacy Name: _____ Address: _____ Phone: _____

Mail Order Name: _____ Address: _____ Phone: _____

CONSENTS

I acknowledge that I have read and agree to the **"NOTICE OF PRIVACY PRACTICES" , "PATIENT RESPONSIBILITIES" and "SCREENING VS. DIAGNOSTIC COLONOSCOPY"** and that a copy can be found on the website and/or be made available to me upon request.
I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **DIGESTIVE CARE PHYSICIANS, LLC** for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to **DIGESTIVE CARE PHYSICIANS, LLC** by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Person providing authorization: _____ Relation to the Patient (if not patient) _____

_____ _____

Patient's/ Parent's/ Guardian's Signature **Date**

Patient Financial Responsibilities

- The patient is responsible for all incurred charges. We will file insurance as a courtesy; however it is the patient's responsibility to provide us with accurate and complete insurance information at the time of their visit. Failure to do so will result in the patient incurring the total expense for their care.

- All patients are expected to provide their insurance card at check-in for every visit.

- The patient is responsible for making sure they know what benefits are included under their insurance plan, as well as making sure they are following all the regulations as put forth in the plan benefits provided to them by their insurance company. Any out of network fees assessed by the insurance company will become patient responsibility.

- Patients are expected to make our office aware of any changes in insurance, home address, phone number and any other pertinent changes.

- Payment is required at time of service for all co-pays, deductibles, and co-insurance. Patients may be required to make payment arrangements on any outstanding balance with our billing department prior to seeing the Provider.

- Patients who do not have insurance are expected to pay for their visit at the time of service unless our billing department has made other payment arrangements.

- There is a return check fee of $35.00 for any check that is returned to our bank. The returned check fee will be required to be paid before your next visit and we will no longer be able to accept checks for future visits.

- You will receive one billing statement showing your balance due. After 30 days unpaid, each additional statement up to 3, will incur a $5.00 statement fee.

- If no payment activity has been made on the patients account within 90 days, the account will be placed with an outside collection agency. The patient will be responsible for any collection fees, costs, interest and/or attorneys fees applied to unpaid balance.

- **It is the patient's responsibility to provide us with a valid referral** from the PCP if required by your insurance prior to their visit. If a referral is not obtained by the patient or provided by the PCP prior to the patients visit, the appointment will be rescheduled for another day. Any balances that are incurred as a result will be the patient's responsibility.

- **There is a $250.00 procedure no-show fee** for patients that do not call to cancel and/or reschedule within 48 hours of the scheduled procedure. There is also a **$25 no-show fee for scheduled office visits.** All patients who do not show up for their scheduled appointments will be responsible for these fees before their next visit. If a patient misses three of their appointments and does not cancel or reschedule, the Provider may discharge them from the practice.

- There may be a $25 fee for forms to be completed by your provider, including FMLA, Disability, etc. Forms will take up to 2 weeks to complete.

- As a courtesy to other patients, any patient that is late for their appointment may be required to wait until other scheduled patients have been seen or reschedule.

- Digestive Care Physicians requires a $25.00 fee for patient requests of their medical records. Payment is due prior to the release of any records. Please note that it takes approximately 10 business days to process medical record requests.

- If you feel you are due a refund on your account, please contact our billing department at 770-227-2222. If a refund is due, they will make arrangements for it to be sent to you.

- Failure to meet your financial responsibilities may also result in discharge from the practice or full payment may be required before continued treatment.

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

SCREENING COLONOSCOPY vs. DIAGNOSTIC COLONOSCOPY

If you are here today because you were sent by your physician for a "Screening Colonoscopy" or you have seen one of our providers and he/she recommends a colonoscopy, please read this form in its entirety. You need to be fully educated on the state and federal guidelines for reimbursement services.

The CMS **"Preventative Screening"** initiative passed in January, 2011 dictates that patients undergoing a **"screening colonoscopy"** will not be held to their coinsurance or deductible responsibilities.

The definition of a "screening colonoscopy" per CMS guidelines is as follows:

> *"A colonoscopy being performed on a **patient who does not have any signs or symptoms in the lower GI anatomy PRIOR** to the scheduled test."*

Any symptom such as change in bowel habits, diarrhea, constipation, rectal bleeding, anemia, etc. prior to the procedure and noted as a symptom by the physician in your medical record may change your benefit from a screening to a diagnostic colonoscopy.

Please Note: If you have had a colonoscopy within the last 10 years and the result indicated you had colon polyps, you are **NOT** eligible for a Preventative Screening Benefit. You have prior history of colon polyps. Your colonoscopy is now a "surveillance of the colon" and is considered diagnostic.

If you are *under* the age of 50 and are here for a screening colonoscopy, you may not be eligible for Preventative Screening Benefits. ***It is your responsibility to know your insurance policy. Please contact your insurance company with benefit questions prior to your procedure.***

Please be advised that if during the procedure your doctor finds a polyp or tissue that must be removed for pathological testing, these specimens are **NOT** covered by the Preventative Screening Benefit and will be applied toward your deductible or coinsurance.

Expect to receive 3 or 4 bills for your procedure:

- Physicians Services
- Anesthesia
- Pathology
- Facility Fee

We make every effort to code correctly for your procedure with the correct modifiers and diagnoses. The correct coding of a procedure is driven by the physician and your medical history. It is not dictated by your insurance benefit or the insurance company.

I acknowledge that I have read and understand these guidelines:

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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

For the purposes of this Notice of Privacy Practices ("Notice"), Digestive Care Physicians, LLC (the "Practice") and the physicians and other health care providers who are members of the Practice's medical staff (the "Medical Staff") work together in an organized health care arrangement to provide medical services to you when you are a patient in one of the Practice's inpatient facilities or outpatient diagnostic and treatment facilities or clinics. However, physicians and other health care providers who are members of the Medical Staff are engaged in the independent practice of medicine and are not employees or agents of the Practice. The Practice and the Medical Staff are referred to collectively in this Notice as "DCP." As health care providers, the DCP providers use confidential personal health information about patients, referred to below as protected health information ("PHI"). DCP protects the privacy of this information, and it is also protected from disclosure by state and federal law. In certain specific circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by DCP or disclosed to other parties. Below are categories describing these uses and disclosures, along with some examples to help you better understand each category.

Uses and Disclosures for Treatment, Payment and Health Care Operations. DCP may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you. In addition, the DCP providers may share your PHI as necessary to carry out its treatment, payment and health care operations related to the organized health care arrangement.

For Treatment. DCP may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment. DCP may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, DCP may need to give PHI to your health plan in order to be reimbursed for the services provided to you. DCP may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. DCP may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. DCP may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of its staff in caring for you, provider training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. DCP may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure DCP is complying with all applicable laws, and to help DCP continue to provide health care to its patients at a high level of quality. DCP may also disclose PHI to other health care providers and health plans for such entity's quality assessment and improvement activities, credentialing and peer compliance, provided that such entity has, or has had in the past, a relationship with the patient who is the subject of the information.

Sharing of PHI Among the Practice and the Medical Staff. As an organized health care arrangement, the Practice and the members of the Medical Staff will share with each other PHI that they collect from you as necessary to carry out their treatment, payment and health care operations relating to the provision of care to patients by DCP.

Other Uses and Disclosures For Which Authorization is Not Required. In addition to using or disclosing PHI for treatment, payment and health care operations, DCP may use and disclose PHI without your written authorization under the following circumstances:

As Required by Law and Law Enforcement. DCP may use or disclose PHI when required to do so by applicable law. DCP also may disclose PHI when ordered to do so in a judicial or administrative proceeding, to identify or locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, the location of the crime or victims, or the identify, description, or location of a person who committed a crime, to report a death or injury resulting from a boating accident, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. DCP may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities. DCP may disclose PHI to the government for oversight activities authorized by law, such as audits investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. DCP may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye, and Tissue Donation. DCP may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donations and transplantation.

Research. Under certain circumstances, DCP may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. DCP may use and disclose PHI, to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. DCP may use and disclose PHI to military personnel and veterans under certain circumstances. DCP may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

Workers' Compensation. DCP may disclose PHI to comply with workers' compensation or other similar laws. These programs provide benefits for understanding or enforcement of labor laws.

Appointment Reminders: Health-related Benefits and Services; Marketing. DCP may use and disclose your PHI to contact you and remind you of an appointment at DCP, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you, such as disease management programs. DCP may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to-face communication or by giving you a promotional gift of nominal value.

Disclosures to You or for HIPAA Compliance Investigations. DCP may disclose your PHI to you or to your personal representative, and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. DCP must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate DCP' compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosure to Which You Have an Opportunity to Object. You will have the opportunity to object to these categories of uses and disclosures of PHI that DCP may make:

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, DCP may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care. DCP may also notify those people about your location or condition.

Other Uses and Disclosures of PHI For Which Authorization is Required. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations you have the right to revoke in writing.

Regulatory Requirements. DCP is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. DCP reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before DCP makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in all patient entry locations. You have the following rights regarding your PHI:

You may request that DCP restrict the use and disclosure of your PHI. DCP is not required to agree to any restrictions you request, but if DCP does so it will be bound by the restrictions to which it agrees except in emergency situations. Effective February 17, 2010, DCP is required by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act") to honor an individual's request to restrict disclosures of PHI to health plans for payment or health care operations purposes if the PHI pertains solely to items and services paid for by the individual in full.

You have the right to request that communications of PHI to you from DCP be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by e-mail rather than regular mail. Your requests must be made in writing and sent to the Privacy Officer. DCP will accommodate your reasonable requests without requiring you to provide a reason for your request.

Generally, you have the right to inspect and copy your PHI that DCP maintains, provided that you make your request in writing to the Practice's Department of Health Information Management. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), DCP will inform you of the extent to which your request has or has not been granted. In some cases, DCP may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request paper copies of your PHI or agree to a summary of your PHI, DCP may impose a reasonable fee to cover copying, postage, and related costs. To the extent capable, DCP will comply with your request for a copy of your PHI in an electronic format. If DCP denies access to your PHI, it will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If DCP does not maintain the PHI you request, if it knows where that PHI is located it will tell you how to redirect your request.

If you believe that your PHI maintained by DCP contains an error or needs to be updated, you have the right to request that DCP correct or supplement your PHI. Your request must be made in writing to the Practice's Department of Health Information Management, and it must explain why you are requesting an amendment to your PHI. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), DCP will inform you of the extent to which your request has or has not been granted. DCP generally can deny your request if your request related to PHI: (i) not created by DCP; (ii) that is not part of the records DCP maintains; (iii) that is not subject to be ing inspected by you; or (iv) that is accurate and complete. If your request is denied, DCP will provide you a written denial that explain the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and DCP's denial attached; and (iii) complain about the denial. You generally have the right to request and receive a list of the disclosures of your PHI that DCP has made at any time during the six (6) years prior to that date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosure for which you have provided a written authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care

operations; (ii) made to you; (iii) for the Practice's patient directory or to persons involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or laws enforcement officials. You should submit any such request to the Practice's Department of Health Information Management, and within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), DCP will respond to you regarding the statue of your request. DCP will provide the list to you at no charge, but if you make more than one request in a year you may be charged a fee for each additional request. You have the right to receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically. You can receive a copy of this Notice at our Web site, digestivecarephysicians.com. To obtain a paper copy of this Notice, please contact the DCP Privacy Officer.

You may complain to DCP if you believe your privacy rights with respect to your PHI have been violated by contacting a Practice Patient Representative or the DCP Privacy Officer and submitting a written complaint. DCP will in no manner penalize you or retaliate against you for filing a complaint regarding DCP' privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services.

If you have any questions about this Notice, please contact the DCP Privacy Officer by Mail at 6300 Hospital Pkwy Ste 450 Johns Creek, GA 30097 or by email at dwilliams@digestivecarephysicians.com

If you have any questions about your medical records, please contact the Medical Records Department by mail at 6300 Hospital Pkwy Ste 450 Johns Creek, GA 30097 or by telephone at (770) 227-2222.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Effective Date: August 2014

Patient Rights

a. Patient has the right to choose another facility for his/her procedure. The patient will be provided a copy of the Patient Rights and Responsibilities prior to the procedure. A copy is also located on the practice website. The provision of this form is delegated to the Medical Practice which shall provide a copy of the signed and dated form to Digestive Care Physicians (Center) prior to the procedure.

b. Some or all of the health care professionals performing services in this Centre are independent contractors and are not Centre agents or employees. Independent contractors are responsible for their own actions and the Centre shall not be liable for the acts or omissions of any such independent contractor

c. The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration and dignity.

d. Patients shall receive assistance in a prompt, courteous, and responsible manner.

e. Patient disclosures medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval. Patients are given the opportunity to approve or refuse the release of their medical records.

f. Patients have the right to know the identity and status of individuals providing services to them.

g. Patients have the right to change providers if they so choose. Patients are informed of the credentials of all staff who will be providing care during the patients' stay.

h. Patients, or a legal authorized representative, have the right to thorough, current and understandable information regarding their diagnosis, treatment options and prognosis, if known, and follow-up care. All patients will sign an informed consent form after all information has been provided and their questions answered.

- When it is medically inadvisable to give such information to the patient, the information is provided to a person designated by the patient or to a legally authorized person.

i. Unless participation is medically contraindicated, patients have the right to participate in all decisions involving their healthcare.

j. Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their provider.

k. Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.

l. Patients have the right to make suggestions or express complaints about the care they have received and to submit such to the Clinical Manager or Practice Administrator who will complete an "Incident Notification" and bring the issue to the attention of the Medical Director in a timely manner so the grievance may be addressed.

m. Patients have the right to be provided with information regarding emergency and after-hours care.

n. Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.

o. Patients have the right to a safe and pleasant environment during their stay.

p. Patients have the right to have visitors at the Centre as long as visitation does not encumber Centre operations and the rights of other patients are not infringed.

q. Patients have the right to have procedures performed in the most painless way possible.

r. Patients have the right to an interpreter if required.

s. Patients have the right to be provided informed consent forms as required by the laws of the State of Georgia.

t. Patients have the right to truthful marketing and/or advertising regarding the competence and capabilities of the Centre and its staff.

u. Patients have the right to have copies of their "Advance Directives" and "Living Wills" in their medical records and to have Center staff honor these wishes to the extent feasible. However, due to the Center's limited capabilities, in the event of an emergency, the patient will be transferred to the nearest hospital at which attending physician has privileges. Hospital staff will be informed of the existence of the Advance Directives and such will be provided if the Center has copies.

v. Patients will be provided, upon request, all available information regarding services available at the Centre, as well as information about estimated fees and options for payment.

w. If applicable, patients will be informed of the absence of malpractice insurance coverage.

x. Patients have the right to approve the release of their medical records to other care providers, legal representatives and other persons authorized by the patient.

y. Patient has the right to exercise his/her rights without being subject to discrimination or reprisal.

z. Patient has the right to be free from all forms of abuse or harassment.

I have received a copy of Digestive Care Physicians Patient Rights

Patient Name: _____ Patient Date of birth : _____

Patient Signature : _____ Date : _____

Patient Responsibilities

a. Patients are expected to provide complete and accurate medical histories, to the best of their ability, including providing information on all current medications, over-the counter products and dietary supplements and any allergies or sensitivities.
b. Patients are responsible for keeping all scheduled pre- and post-procedure appointments and complying with treatment plans to help ensure appropriate care.
c. Patients are responsible for reviewing and understanding the information provided by their Physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required for obtaining coverage.
d. Patients are responsible for providing insurance information at the time of their visit and for notifying the receptionist of any changes in information regarding their insurance or medical information.
e. Patients are responsible for paying all charges for co-payments, co-insurance and deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with the Administrative Director.
f. Patients are responsible for treating Physicians, Staff and other patients in a courteous and respectful manner.
g. Patients are responsible for asking questions about their medical care and to seek clarification from their Physician of the services to be provided until they fully understand the care they are to receive.
h. Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
i. Patients are responsible for expressing their opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Centre.
j. Patients are responsible for notifying their health care providers of patient's Advance Directives, Living Wills, Medical Power of Attorney or any other directives that could affect their care. In the event of an emergency, the patient will be transferred to the appropriate facility. The facility will be notified of the existence of the Advance Directive, if applicable, and will be provided with a copy.
k. Patients are responsible for having a responsible adult transport them from the Centre and remain with the patient for twenty-four (24) hours, if required by the Physician.
l. The patient will be provided a copy of the Patient Rights and Responsibilities prior to the date of the procedure. The provision of this form is delegated to the Medical Practice which shall provide a copy of the signed and dated form to the Centre prior to the procedure.

Questions or Concerns?

You and your family should feel you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss your concerns with your doctor, nurse, or other caregiver. If you have concerns that are not resolved, please contact Kathy Price, the Clinical Supervisor, at (770)-227-2222.

PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance, you can contact the Dennis Williams, Practice Administrator 770-227-2222 or by mail at:
Digestive Care Physicians, LLC, 6300 Hospital Pkwy Ste 450 Johns Creek, GA 30097.

Complaints and grievances may also be filed through the: Department of Community Health, Division Chief, Healthcare Facility Regulation Division, 2 Peachtree St, NW, Suite 31, Atlanta, Georgia 30303, (404) 657-5728 or (800) 878-6442.

You may also file a complaint with the Georgia Board of Medical Examiners at (404) 656-3913
Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman at:
www.cms.hhs.gov/center/ombudsman.asp or (800) Medicare

Disclosure of Ownership Interest
The Practice is owned by Dr. Ranvir Singh and Dr. Stephen Rashbaum. Drs. Singh and Rashbaum have become owners due to the commitment to provide quality health care and services to patients at a more affordable cost. You have the right to choose where to receive services, including the following reasonable alternative source of services for the physician:

- Emory Johns Creek Hospital
- Northside Forsyth Hospital

I have received a copy of Digestive Care Physicians Patient Responsibility

Patient Name: _____ Patient Date of birth: _____

Patient Signature : _____ Date : _____

Date: _____

Patient Name _____ **Date of Birth**_____
Age _____ **Height**_____ **Weight**_____
Allergies (*Medication, Latex, Food, Other*)
_____
Current Medications – Prescription and Non-Prescription (*Include all over-the-counter medication; herbal supplements; complementary or alternative medicines*) _____
_____
_____

Prior Surgeries or Procedures (*including dental*):_____
_____

Any Personal or Family History of Anesthesia Complications? (*Please specify*): _____
_____

Are you currently experiencing any of the following? (Circle appropriate response)

Heartburn	Yes /No	Abdominal pain	Yes /No
Trouble Swallowing	Yes /No	Constipation	Yes /No
Weight loss	Yes /No	Diarrhea	Yes /No
Anemia	Yes /No	Bloating	Yes /No
Bloating/Gas	Yes /No	Change in bowel habits	Yes /No
Nausea/ Vomiting	Yes /No	Constipation	Yes /No
Rectal bleeding	Yes /No	Decreased Appetite	Yes /No
Feeling Full Quickly	Yes /No	Chest pain/shortness of breath	Yes /No
Diverticulosis/Diverticulitis	Yes /No	Personal/Family history of colon polyps or gastrointestinal cancer	Yes /No

Past Medical History (*please specify if you have a history of any of the above previous gastrointestinal conditions*)
_____
_____

Other Past Medical History (please state if you have had the following):

Heart Disease (Including: heart murmur, pacemaker, catheterization, stents, mitral valve prolapse, heart attack, heart surgery, irregular heart rhythm, congestive heart failure) Specify (include year of diagnosis, if known)_____
_____
High blood pressure (Yes/No)
Do you use nitroglycerine? (Yes/No) *How often/*last nitroglycerine use/(date)?
_____
Can you exercise at your own pace without shortness of breath ? (Yes/No) Activity type? _____
_____
Previous EKG/Stress test/echocardiogram results _____ Date(s)
_____
Swelling of extremities? (Yes/No) Specify
_____
Chest pain/Angina (Yes/No) Specify _____
Lung Disease
Asthma/COPD/Emphysema (Yes/No) Specify
_____
Most recent hospitalization or ER visit (Yes/No) Specify
_____
Home oxygen use (Yes/No) Frequency?
_____
Chronic Cough (Yes/No) Abnormal chest x-ray (Yes/No)
Sleep Apnea (Yes/No) CPAP (Yes/No) Central or obstructive (*circle if known*)
Tuberculosis (Yes/No) Positive PPD (Yes/No) Specify year of treatment _____
Shortness of breath? (Yes/No) Specify _____

Kidney disease (Yes/No) Specify_____ Difficulty voiding (Yes/No) Specify _____

Liver disease
Hepatitis/Jaundice/Cirrhosis (Yes/No) Specify
_____

Neurologic Problems
Epilepsy/Seizures/Stroke (Yes/No) Specify _____ Last episode_____
Any residual problem (Muscle weakness, difficulty swallowing, etc)
_____
Psychological conditions (depression, anxiety, bipolar disorder, schizophrenia, etc)
Specify_____

Autoimmune disorders/Connective tissue disorders/Lupus/SarcoidosisSpecify_____
_____

Endocrine
Thyroid or goiter problems
Specify_____
Diabetes (Yes/No) _____ Year diagnosed _____ Do you take insulin (Yes/No)

Musculoskeletal/paralysis/ muscle disease (Yes/No)
Specify_____
Back and/or neck problems (Yes/No)
Specify_____
Muscle Weakness (Yes/No)
Specify_____
Metal implants (back, hip, knee, etc)
Specify_____

Social history
Do you or have you ever smoked? (Yes/No) Amount per day _____ How many years?_____
Year quit _____ Use(d) smokeless tobacco (Yes/No) How many years
_____
Use(d) recreational drugs (Yes/No) Type(s)_____ How often? _____ How many years?_____
Use alcohol (Yes/No) Type(s)(Beer/wine/liquor) _____How often?_____ Quit? (year)_____
Been treated for substance abuse (Yes/No) Year_____

History of Infectious Disease
Have you had a recent cold, flu or infection (Yes/No) Specify _____Date _____

Blood & Platelets
Bleeding or clotting abnormalities (Yes/No)
Specify_____
History of blood transfusion (Yes/No)
Specify_____

Eyes
Glaucoma (Yes/No) Use eye drops (Yes/No)

Other Disorders
Specify_____

_____ _____ _____
Patient Signature Parent, Guardian, or Power of Attorney Relationship

Date: _____ **(If patient is unable to sign)**

Digestive Care Physicians, LLC

Gastroenterology • Hepatology • Therapeutic Endoscopy
Ph: 770-227-2222 • Fx: 770-227-2220
6300 Hospital Pkwy, Suite 450 • Johns Creek, GA 30097
3970 Deputy Bill Cantrell Memorial Road #210. • Cumming, GA 30040
3400-C Old Milton Parkway, Suite 285 Alpharetta, GA. 30005

www.digestivecarephysicians.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date: _____

Patient Name: _____

Date of Birth: _____

Social Security No: _____

Phone Number: _____

All Records History & Physical

Lab US / CT / MRI

Endoscopy

Other _____

Mail Pickup Fax

Purpose or need for information: _____

_____

I hereby authorize that Digestive Care Physicians, LLC: ***RELEASE/OBTAIN: (circle one)***

the protected health information regarding the above named person to / from:

Person/Institution: _____ _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION ON RE-DISCLOSURE: Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal regulation (42 CFR Part 2) prohibits recipients from making any further disclosure of this information except with specific written consent of the patient. HIV testing, ARC and/or AIDS related diagnosis is further prohibited from disclosure by State. Regulations without the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for this purpose.

RE-DISCLOSURE: Notice is hereby given to the patient of legal representative signing this Authorization that Digestive Care Physicians, LLC cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and / or alcohol abuse, HIV and mental health treatment.

Signed _____ (Patient or Legal Guardian) Witness: _____

_____

(If Guardian signed, Relationship to Patient)

Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement: Discrimination is Against the Law

Digestive Care Physicians, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Digestive Care Physicians, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Digestive Care Physicians, LLC :

> Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters. Provides free language services to people whose primary language is not English, such as: Qualified interpreters.

If you need these services, contact **Dennis Williams**
If you believe that Digestive Care Physicians, LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Dennis Williams, 6300 Hospital Parkway Suite 450, Johns Creek, GA. 30097 Telephone number 770-227-2222, Fax 770-227-2220, Email: dwilliams@digestivecarephysicians.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [Dennis Williams] is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame
Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務
Tagalog/Filipino:
Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Arabic:
ةظوحلم: اذإ تدحتت تنك ركذا ةيوغللا ةدعاسملا تامدخ نإف، ةغللا مقرب لصتا. ناجملاب كل رفاوتت
French Creole:
Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
French:
Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Portuguese:
Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Italian:
In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
German:
Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Thai:
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี
Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Polish:
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Gujarati:
ચુના: જો તમે □જરાતી બોલતા હો, તો િન:□લ્કુ ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ.