Welcome to the Office of **Appt:**
Colorado Center for Digestive Disorders
205 S. Main St., Suite A, Longmont, CO 80501
Phone Number: 303-776-6115 Fax Number: 303-776-4318

PLEASE READ, MAKE SURE ALL INFORMATION IS CORRECT AND SIGN ALL 6 PAGES

PATIENT INFORMATION: ❑ **New Patient** ❑ **Update**

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Social Security Number: _____ **Date of Birth:** _____

Home Phone: _____**Cell/Business Phone:** _____

E-mail address: _____ **Marital Status:** _____

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

Referring/Primary Physician (PCP): _____**Last office visit with PCP:** _____

Pharmacy Name & Address: _____ **Employer:** _____

Is it okay to leave messages on your answering/voicemail machine regarding your health care? ❑ **Yes** ❑ **No**

Race & Ethnicity (Census Bureau Categorization Purposes): American Indian or Alaskan Native: _____ Asian: _____
African American: _____ Black Hispanic or Latino: _____ Caucasian: _____ White Hispanic or Latino: _____
Native Hawaiian and other Pacific Islander: _____ Refused: _____ Language Preference: _____

MEDICAL INSURANCE INFORMATION: ❑**Referral on file** ❑ **No Insurance/Self Pay**

Primary Insurance Company: _____ **Telephone:** _____

Address:_____

Subscriber/Member ID: _____ **Group #:** _____

Policyholder name: _____ **DOB/SS#:**_____
(If different than patient)

Secondary Insurance: _____**Subscriber ID/Group:**_____

Patient's Signature: _____ Date: _____

All information herein, pages one through six, valid per my electronic signature.

DL/ID___ Insurance Card___ Paperwork___ Financial Agree.___ Verified___
Prior Nursing Notes___ Copay/Dec___ Pt notified___ Amount Due_____

PATIENT HISTORY FORM

Patient: _____ Age: _____ Date of Birth: ____/____/____Date of last Physical Exam____/____/____

Do you have a DNR/Living Will? _____ Do you have a copy with you? _____ Referring Physician: _____

The Reason for Your Visit: EGD___ Colonoscopy___ Sigmoidoscopy___ HEIGHT_____ WEIGHT_____

_____

_____

Patient Profile: Married___ Divorced___ Single___ Separated___ Widowed___ Partner____ Religious Preference: _____

Occupation: _____ Yrs Retired: _____ since: _____ Hobbies/Interests: _____

Habits: Tobacco: Pipe____ Chewing Tobacco____ Cigarettes____ Other_____ How much_____# of Years _____

COFFEE/CAFFIENE: More Than 2 cups/sodas per Day_____ ALCOHOL/BEER: Frequency/Amount_____

Do you have or have you had the following? IF YES, PLEASE EXPLAIN BELOW:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cardiac Stents
- ☐ Metal Implants (site)_____
- ☐ Pacemaker (type)_____
- ☐ Artificial Heart Valve
- ☐ Irreg. Heart Beat
- ☐ Bleeding Disorder (type)_____
- ☐ Anemia
- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Sleep Apnea
- ☐ CPAP
- ☐ O2_____L
  Continuous____ Night only___
- ☐ Infectious Disease___ HIV___
- ☐ Liver Disease___ Hepatitis___
- ☐ Gallbladder Disease
- ☐ Pancreatitis
- ☐ Kidney Disease
- ☐ Kidney removed
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Colon polyps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcers (type)_____
- ☐ Esophageal Reflux
- ☐ Heartburn
- ☐ Arthritis
- ☐ Cancer (location)_____
- ☐ Frequent Headaches
- ☐ Stroke
- ☐ Dizziness
- ☐ Seizures
- ☐ Anxiety
- ☐ Depression
- ☐ Eczema
- ☐ Hives/Rashes
- ☐ Glaucoma
- ☐ Previous Adverse Reaction to Sedation
- ☐ ****Is there any possibility of pregnancy?**

Date of last menstrual period __/___/___

Other medical problems not listed:_____

Previous Surgeries/Hospitalizations: _____

_____

Previous Endoscopies, i.e.: Colonoscopy, EGD, ERCP: _____

Family History

	Father	Mother	Sibling		Father	Mother	Sibling
Gallstones				**Ulcers**			
Colon Polyps				**Pancreatitis**			
Type of Cancer				**Liver Disease**			
Bleeding Disorders				**Cirrhosis/Hepatitis**			

*****Patient Signature: _____ Date: _____*****

Reviewed By: _____ Date: _____ Physician Signature: _____ Date: _____

************************FOR OFFICE USE ONLY************************

Pre-op Call: Date: _____ Spoke with: _____ Nurses Signature: _____

Post Op Call: Date: _____Spoke with: _____ Nurses Signature: _____ Letter Sent: _____

How did you tolerate the procedure: _____ Side effects or complications? _____

Colorado Endoscopy Centers

Patient Medication/Reconciliation Form

**Allergies/Sensitivities*	Reaction	**Allergies/Sensitivities**	Reaction

****LATEX ALLERGY/SENSITIVITY? _____ Reaction: _____****

List all prescription and non-prescription medications taken daily or routinely. **Including birth control, vitamins, dietary supplements, arthritis and pain medications**

Do you take any blood thinners such as Plavix, Coumadin, Warfarin, Aspirin? _____

Do you use Marijuana for medical use? _____ Recreational use? _____ How many times per week? _____

*Current Medications	*Dose	* How many times a day	*Reason

*****PATIENT SIGNATURE _____ DATE_____*****

PRINT PATIENT NAME_____RN VERIFICATION_____ DATE_____

*********FOR OFFICE USE ONLY*********

Medications have changed. Patient instructed to give updated medication form to primary physician_____

New Prescriptions	Dose	Frequency	Comments

This list is for the purpose of patient education and as such, Colorado Endoscopy Center is not responsible for the resumption of the medication or the efficacy of the listed medications.

COLORADO CENTER FOR DIGESTIVE DISORDERS

COLORADO ENDOSCOPY CENTERS

FINANCIAL POLICY STATEMENT

We will assist you to receive your maximum allowable benefits if you have medical insurance. Co-pay/Deductible payment for services is DUE AT THE TIME SERVICES ARE RENDERED, unless our billing office has approved payment arrangements in advance. We accept CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER. Returned checks will be subject to a $25.00 return fee and a 1.75% interest fee per month will be added to all balances older than 30 days until paid in full. **All balances are due within 90 days.**

1. **INDIVIDUALS WITH PRIVATE OR COMMERCIAL INSURANCE**
   We will be happy to process your insurance claim for your reimbursement. A CURRENT INSURANCE CARD MUST BE PRESENTED AT YOUR VISIT AND CO-PAYMENTS/DEDEUCTIBLE ARE DUE AT THIS TIME. Payment is your responsibility:
   a. Your insurance is a contract between YOU, YOUR EMPLOYER, and the INSURANCE COMPANY. We are not a party to that contract.
   b. Not ALL services are a covered benefit in all contracts. Some insurance contracts select certain services that they will NOT cover. If you receive a non-covered benefit, you are responsible for payment of the full billed charges.
   c. If insurance has not paid your claim or responded within 60 days, THE PATIENT IS RESPONSIBLE FOR FOLLOWING UP WITH THE INSURANCE COMPANY AND PAYMENT IS DUE.

2. **INDIVIDUALS WITHOUT MEDICAL INSURANCE**
   We require payment in full at the time of service from patients who do not have medical insurance unless prior arrangements are made with our office.

3. **MEDICARE**
   Claims will be filed to Medicare and your secondary insurance.

4. **INCORRECT OR INCOMPLETE INSURANCE INFORMATION**
   Incorrect or incomplete insurance or personal information makes accurate submission of insurance claims impossible. If this situation occurs, patient/insured will be immediately responsible for the charges in full.

5. **REFERRALS**
   It is the patient's responsibility to know if their insurance requires them to have a referral. If you are not sure, please contact your insurance. If your insurance does require a referral, it is YOUR responsibility to have the referral in place PRIOR to your office visit and/or procedure. If there is no referral, you will be responsible for the charges in full.

6. **NO SHOW**
   Our office must be notified of appointment cancellations at least 3 days in advance of your scheduled office visit. We retain the right, at C2D2/CEC sole discretion, to charge $75.00 for non-cancellation of your appointment for office visit and $300.00 for procedure appointment. Emergency cancellations for illness or family emergencies MAY be required to submit written documentation to avoid cancellation fee. **A reminder your insurance will not pay for your missed appointment and payment is due immediately.**

We must emphasize that as a provider of medical services, our relationship is with YOU, not your insurance company. While the filing of patient insurance forms is a courtesy that we extend to our patients, all charges are **YOUR** responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Authorization: I have read and agree to the terms and conditions. I hereby authorize the release of medical information necessary to process my health insurance claim and request payment of benefits to the provider of services. I understand I am financially responsible to C2D2/CEC for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, the cost of collection and/or court costs and reasonable attorney fees will be added should this be required. I have read all the information on this sheet and I am aware of my financial responsibility.

*****Patient Signature _____Date:_____*****

NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following: ***Treatment***. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer***. Payment***. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment. ***Healthcare Operations***. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice. ***Other Uses or Disclosures.*** We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following: To avoid a serious threat to your health or safety or the health or safety of others. As required by state or federal law such as reporting abuse, neglect or certain other events. As allowed by workers compensation laws for use in workers compensation proceedings. For certain public health activities such as reporting certain diseases. For certain public health oversight activities such as audits, investigations, or licensure actions. In response to a court order, warrant or subpoena in judicial or administrative proceedings. For certain specialized government functions such as the military or correctional institutions. For research purposes if certain conditions are satisfied. In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes. To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below: To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment: To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclose your religious affiliation to clergy.

3. Uses and Disclosures with Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information: To exercise any of these rights, you must submit a written request to the Office Manager. You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer. We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests. You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete. You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period. You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes to This Notice. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Office Manager. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Colorado Center for Digestive Disorders endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time.

8. Effective Date. This Notice is effective September 23, 2013

Date: _____ Print Name: _____ Relationship to Patient: _____

Signature: _____

COLORADO CENTER FOR DIGESTIVE DISORDERS
(Waiver of Non-Covered Services)
(Advanced Beneficiary Notice)

This waiver allows a network (contracted) provider to collect billed charges for services denied as "non-covered" services from a patient when the patient has agreed, in writing, to waive his or her balance-billing protection.

I, _____, the patient, hereby agree to pay the full billed charge(s) for the following service(s) if such service is subsequently denied as non-covered (not an Insurance Benefit) regardless of the fact that my insurance company will not make payment. I understand these charges are estimates only and I will be responsible for all charges incurred for the provision of these healthcare services.

Your Insurance/Medicare/Medicaid may only pay for services it determines to be "reasonable or medically necessary" under the terms of your insurance contract. If your Insurance/Medicare/Medicaid determines that a service, although it might be otherwise covered, is not reasonable and necessary according to their standards, payment may be denied for that service.

Date: ____/_____/_____Procedure: _____ Office Visit: _____

Note: This waiver applies to any and all Insurance Companies including Medicare and Medicaid non-covered services indicated above rendered by this provider, including, but not limited to office visits, office procedures, hospital visits, and surgical fees.

_____

I acknowledge I am signing this statement voluntarily and it is not being signed under duress or after the services have already been provided. I understand by signing this form, I will be fully responsible for the total billed charge(s) for any services denied as non-covered (not a covered insurance benefit) and listed above and will pay the provider the amount, regardless of the fact my Insurance will not make payment. I also understand it is my choice to have these services provided at a future date and time by this provider.

Patient Name (Printed): _____ DOB: ____/____/____

*****Patient Signature: _____*****