

# Digestive Disease Associates, P.A.

## Patient Information

Welcome to our office!

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patients Name (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City and State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
SS#

\_\_\_\_\_  
Race

\_\_\_\_\_  
Marital Status

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Referring Physician /Phone #

\_\_\_\_\_  
Primary Care Physician/Phone #

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Address

\_\_\_\_\_  
City and State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Insured Name ( If not same as patient)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
SS#

\_\_\_\_\_  
Emergency Contact

\_\_\_\_\_  
Address

\_\_\_\_\_  
Contact Phone

### PLEASE READ THE FOLLOWING INFORMATION:

- This office participates with many insurance plans, including Medicare/Medicaid. We will file your visit if we participate with your insurance company. If we do not participate with your insurance plan, payment is expected at the time of service.
- Patients are responsible for notifying the business office of any changes in insurance coverage and changes of address.
  - Plan co-payments are due at the time of service.
- Patients are responsible for balances due to deductibles, copayments, or insurance non-payment according to their plan.
- Patients are responsible for notifying the Patient Coordinator if referrals are needed

# Medical History Update

\_\_\_\_\_

Date

\_\_\_\_\_

Patient Name ( Please Print)

Today's Complaint: \_\_\_\_\_

Previous Surgeries :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication Allergies or Reactions- \_\_\_\_\_

Present Medications:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Frequently Used Non-Prescription Medications:

Aspirin: \_\_\_\_\_ How Much? \_\_\_\_\_

Laxatives: \_\_\_\_\_ How Much? \_\_\_\_\_

Social History:

Do You Smoke? \_\_\_\_\_ How Much? \_\_\_\_\_

Do You Drink? \_\_\_\_\_ How Much? \_\_\_\_\_

History of HIV+, Aids or Exposure to? \_\_\_\_\_

History if Tuberculosis, Positive Skin Test or Exposure To? \_\_\_\_\_

Thank you for allowing us to participate in your health care needs. The rising cost of medical care is of great concern to us and we attempt to deliver high quality health care at the lowest possible costs. Our office staff is happy to discuss fees with you at any time.

It is our policy to request payment for the services at the time they are rendered. Our office will file all claims and we request all co-pays be paid when services are rendered.

As a service to our patients, we will file claim forms for procedures or consultations done in the hospital. You are responsible however, for any balance remaining after your insurance carrier had paid or rejected our claim. In all situations, you, not your insurance company, are ultimately responsible for all charges.

**Authorization To Pay Benefits To Physicians:**

I hereby authorize payment directly to Digestive Disease Associates of York County, P.A. of the surgical and/or medical benefits if any otherwise payable to me for this service rendered me in the office and /or Piedmont Medical Center, York County Endoscopy Center.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Authorization to Release/Request Medical Information:** I hereby authorize all treating Physicians, hospitals, insurance companies, and other medical institutions to release/request any and all information regarding my physical condition and treatment which may be requested by them to aid in medical treatment or processing claims.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# PLEASE READ CAREFULLY

## DISCLOSURE/AGREEMENT

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### REASON FOR TODAY'S VISIT:

Routine Preventive Exam ( I have no medical complaints or problems/abnormalities 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 your 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 to pay for any and all medical services I receive from the Doctor/Provider of this practice that my insurance company refuses to pay. This office will file a claim on my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, does not pay for preventive or routine visits, my failure to secure a referral from my primary physician), I will pay for same upon written/verbal notice of their refusal.

I further 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 a fraud.

Patient ( or responsible party if  
minor) \_\_\_\_\_

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.

NIRAV N. PATEL, M.D.

170 AMENDMENT AVE.  
ROCK HILL, SC 29732

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

**Acknowledgement of Receipt of Privacy Practices**

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of (6) years.

\_\_\_\_\_  
Signature of Patient/Representative and Relationship to patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Practice Representative

\_\_\_\_\_  
Date

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

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_