

– powered by –



Welcome to Our Practice!

Please fill out the information found below to the best of your ability.

Date of Birth				Physician				_	Today's Date		
Patient Name											
Why are you here	today?	-									
				F	Patient Med	dical	History				
		Наν	/e you e	ever had the fo	ollowing? (Che	eck no	o, yes, or le	ave bla	nk if uncertain	ı.)	
Arthritis		□No	☐ Yes	Plasma Tran	sfusions	□No	□ Yes	Mitral V	alve Prolapse	□No	□ Yes
Anemia		□No	☐ Yes	Blood Trans	fusions	□No	□ Yes	Stroke		□No	□ Yes
Epilepsy		□No	☐ Yes	Low Blood F	Pressure	□No	□ Yes	Hepatiti	S	□No	□ Yes
High Blood Pressu	ure	□No	□ Yes	Hemorrhoid	S	□No	☐ Yes	Peptic U	llcer Disease	□No	□ Yes
Migraine Headach	hes	□No	☐ Yes	Asthma		□No	□Yes	Kidney I		□No	□ Yes
Tuberculosis		□No	□ Yes	Heart Attack	<	□No	□Yes	Overact	ive Thyroid	□No	□ Yes
Diabetes		□No	□ Yes	Stents Plac	ced	□No	□ Yes	Underad	ctive Thyroid	□No	□ Yes
Cancer		□No	□ Yes	AIDS or HIV	+	□No	□ Yes	Bleeding	g Tendency	□No	□ Yes
If yes, what kind	/ ?			Infectious M	ono	□No	□ Yes		ner Disease	□No	□ Yes
Polio		□No	□ Yes	— Atrial Fibrilla	ation		□ Yes	-	ist other:		
Glaucoma			□ Yes	Sleep Apne			□ Yes				
Hiatal Hernia		□No	□ Yes	Use CPAP		□No	□ Yes				
Inguinal Hernia		□No	□ Yes	Defibrillator		□No	□ Yes				
Incisional Hernia		□No	□ Yes	Pacemaker		□No	□ Yes				
<u>Surgeries</u>							<u>When</u>		<u>Hospital, C</u>	<u> Jity, State /</u>	Province
When / Where wa When / Where wa				y?				_			
					Patient So	cial I	History				
Marital Status: Occupation:		□ Sing	gle	□ Married	□ Separa	ted	□ Divorce	ed -	□ Widowed Number of Chi	ldren:	
Alcohol Use:	□ Never		□ Oc	casionally – Drink	s per Week			□ Dailv -	– Drinks per Day _		
Tobacco Use:	□ Never			viously, but Quit	•				ntly – Packs per D		
				ien Did You Last S						,	
Illegal Drug Use:	□No			s, Type & Frequer							
					-						
					Family Med	dical	History				
Any Family Medic	-	-	•								
·											
	• 1										
									<u> </u>		
	ative Colitis										

(Please make sure your	Name, DOB & To	oday's Date are	listed above.
------------------------	----------------	-----------------	---------------

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL				
YES				
Weight Loss				
Fever				
Fatigue				

RESPIRATORY					
YES NO					
Chronic Cough					
Spitting Up Blood					
Wheezing					
Snoring					

CARDIOVASCULAR					
YES NO					
Chest Pain					
Shortness of Breath					
Swelling in Ankles					

GI		
	YES	NO
Difficulty Swallowing		
Heartburn		
Nausea		
Vomiting		
Bloating		
Belching		
Regurgitation		
Constipation		
Diarrhea		
Abdominal Pain		
Rectal Bleeding		
Rectal Pain		
Poor Appetite		

GENITOURINARY					
	YES	NO			
Possibility of Pregnancy					
Blood in Urine					
Currently Breastfeeding					
Burning with Urination					
Incontinence of Urine					
Irregular Periods					

NEUROLOGICAL					
YES NO					
Seizures					
Numbness/Tingling					
Weakness					
Headaches					

MUSCULOSKELETAL						
YES NO						
Back Pain						
Joint Pain						
Muscle Pain						

ENDOCRINE					
	YES	NO			
Excessive Thirst					
Heat Intolerance					
Excessive Urination					
Cold Intolerance					

PSYCHIATRIC					
	YES	NO			
Depression					
Anxiety / Nervousness					
Confusion					
Memory Difficulty					
Insomnia					

INTEGUMENTARY					
YES NO					
Itching					
Rashes					

HEMATOLOGIC / LYMPHATIC				
	YES	NO		
Easy Bleeding				
Easy Bruising				
Anemia				
Sickle Cell Anemia				
Enlarged Glands				
Rejected for Blood or Plasma Donation				

ENMT						
	YES	ОИ				
Sore Throat						
Hearing Loss						
Ringing in Ears						
Mouth Sores						
Taste Change						
Sore Tongue						

ALLERGIC / IMMUNOLOGIC				
	YES	ОИ		
HIV Exposure				
Persistent Infections				
Strong Allergic Reaction or Urticaria				

EYES		
	YES	NO
Loss of Vision		
Blurred Vision		

Known Food Allergies:	
Environmental Allergies:	
3	

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

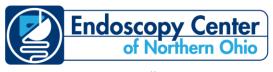
SIGNATURE:	DATE:

(Please make sure your Name, DOB & Today's Date are listed above.)						
				Pharmacy Phone #:		
Do you have a mail order p	orescription program? 🗆 N	1O □ YE	S If YES, with whom?			
Allergies:						
Plaasa list all nra	scribed medicatio	ns incl	uding vitamins	over-the-counter, and as needed.		
-			HOW MANY			
MEDICATION	PRESCRIBED BY	DOSE	TIMES PER DAY	REASON		
1		1	ĺ			

Today's Date: _____

Patient Name & DOB: _____





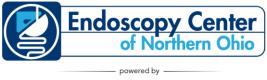




PLEASE FILL OUT ENTIRE FORM

Patient's Name:								TODA	Y'S DATE:	
Date of Birth (DOB):	-			Current Age	e:			Sex:	□ MALE	□ FEMALE
Address:										
Home Phone:										
	_		•							
Spouse's Name:						DOB:		Phone #:		
Family Doctor/PCP:										
May we leave a mes	ssage:	On your void Via Email 🗆	cemail/answering No 🗆 Yes	_				Via Text Messag		Yes
Employer / School:							Occupatio	on:		
WHO CAN WE SPE Name:								Polationship		
N.										
								•		
							_	rtelationship:		
EMERGENCY CON	ITACT: (pł	none # must l	ne different than	natient's pho	ne #)					
						:		Rela	tionship:	
Responsible Party	for Insurai	nce & Medic	al Bills: □ Patien	t 🗆 Spouse	□ Pare	nts 🗆 l	Mother 🗆	Father 🗆 Othe	er	
				,						
Primary Insurance C	ompany:	-								
Subscriber Name:								Subscriber DC	DB:	
Insurance ID #:							_	Insurance Group) #:	
Relationship to Card	d Holder:	□ Self □ S	pouse 🗆 Depe	ndent C	ard Copi	ed: 🗆 Y	ES 🗆 NO	Co-Pa	yment: \$	
Secondary Insurance	e Compar									
Subscriber Name:										
Insurance ID #:							_	Insurance Group) #:	
FOR MIN	ORS C	NLY								
Child lives with:	□ Both Pa	arents 🗆 Mo	other 🗆 Father							
Mother / Guardian:							_	Date of Birth:		
Address (street, city	, state & z	ip – if differei	nt):							
Home Phone:			Work	Phone:				Cell Phone:		
Father:							_	Date of Birth:		
Address (street, city	, state & z	ip – if differei	nt):							
Home Phone:			Work	Phone:				Cell Phone:		









Privacy Consent – For the Use & Disclosure of Protected Health Information (PHI)

This consent is required by the Health Insurance Portability & Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to DDC and the Endoscopy Center of Northern Ohio to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient / Guardian Signature:	
Name Printed:	If not patient, relationship:
Copy of Practice Privacy statement signed or initiated with patient / guardia	n on:
Patient unable to sign privacy statement due to:	
REVOCATION hereby revoke the consent given above:	
Patient / Guardian Signature:	Date:
Name Printed:	If not patient, relationship:
Consent for assignment of benefits: I consent to assign all payments for these	·

required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of

the contract, I am aware that I may be responsible for all charges that are incurred.

Patient / Guardian Initials:

Bipin Sharma, MD, MRCP (UK)
David Myers, MD
Fadi Bashour, MD
Richard Del Rio, MD, MS, MBA
Maya Merheb, MD



1299 Industrial Parkway North, Ste 110 Brunswick, OH 44212

3985 Medina Road, Ste 120 Medina, OH 44256

500 East Royalton Road, Ste 100 Broadview Heights, OH 44147

BILLING POLICY

We now require all deductibles and co-pays be paid prior to or at the time of service.

Any outstanding balances are to be paid in full within a 90-day grace period. All accounts over **90 days old are subject to a monthly interest charge of 1.5%, annual rate of 18%**.

Please make every effort possible to satisfy balances accordingly to avoid accumulating interest and possibly having your account turned over to a collection agency. Patients who have their accounts turned over to a collection agency are discharged from our Practice and are subject to an additional \$25.00 collection fee.

If you have any questions regarding this policy speak to a member of our Billing Department.

CANCELLATION / NO-SHOW POLICY

At Digestive Disease Consultants and the Endoscopy Center of Northern Ohio, our goal is to serve our patients with quality care in a timely manner. To provide the best care in a timely manner, we must implement a cancellation / no-show policy to ensure availability in the office, as well as in our ambulatory surgical center for our patients who are in urgent need of care.

We ask every patient to be considerate to others and to please cancel an appointment in advance so that another patient can be cared for in a timely manner as there is a high demand for available appointments.

We understand that there are circumstances and emergencies prohibiting early cancellation and thus these circumstances will be considered, and a one-time exception can be granted based on the situation. Otherwise, if you do not cancel within 24-hours of your appointment, you will be subject to a cancellation / no-show fee of \$100.00. This fee is not covered by insurance and as a patient of this practice, it will your full financial responsibility.

How to Cancel Your Appointment

To cancel your appointment, please call the Digestive Disease Consultants office at 330-225-6468, Monday-Friday 8:00 AM through 4:30 PM. You can also call our answering service 24-hours a day at 888-445-9932. If you are having problems reaching our staff, please leave a message with your name, date of birth, and your reason for calling.

I have read these policies in full;	I understand and agree to the terms	of these policies.
Printed Name:		DOB:
<mark>Signature</mark> :		
Date:	Time:	

PHONE: 877-891-ENDO (3636) FAX: 330-225-6534