



Dear New Patient:

Welcome, and thank you for choosing us!

The enclosed packet contains important information for your upcoming appointment as well as our new patient registration forms. To be prepared for your appointment, please review this information carefully and bring the requested information with you on the day of your appointment.

It is very important to bring the following to your first visit:

- √ Completed Patient Information Forms, Patient History Forms & Signed Notice of Privacy Practices (enclosed in this packet)
- √ Insurance Card(s) and Insurance Referral, if applicable
- √ Picture Identification (such as a driver's license)
- √ A list of your current medications with dosage and frequency taken
- √ Any recent Laboratory (blood work) results related to your visit with us
- √ Any recent Radiology results related to your visit with us (e.g. Upper GI Testing, Barium Enema, CT scan or Ultrasound results)
- √ For patients enrolled in HMO plans, a referral may be required from your Primary Care Physician. Please check with your Insurance carrier to verify the requirements of your plan √ Co-payment, if applicable. Please note that payment is due at the time of service.

Providing the above information on the day of your appointment will allow us to serve you in the most prompt, accurate and efficient manner.

Thank you for allowing us to participate in your medical care.

We look forward to seeing you soon!



Patient Demographics

Patient Last Name:	Patient First Name:	Patient MI:
Preferred Name:	SSN:	Date of Birth:
Gender:	Age:	Race / Ethnicity:
Patient Address:	City & Zip Code:	Driver's License:
Cell Phone:	Home Phone:	Work Phone:
Email address:	Marital Status:	Occupation:
Guarantor:	Phone:	Circle: Home / Cell / Work
Emergency Contact:	Phone:	Circle: Home / Cell / Work
Referring Physician:	Primary Care Physician:	Preferred Language:

Primary Insurance Coverage:

Carrier:	Plan ID / Name:	Effective Date:
Group ID / Name:	Member Policy ID #:	
Subscriber Name:	Subscriber DOB:	Patient Relationship to Subscriber:
Subscriber Employer:	Claims Address:	Carrier Phone:

Secondary Insurance Coverage:

Carrier:	Plan ID / Name:	Effective Date:
Group ID / Name:	Member Policy ID #:	
Subscriber Name:	Subscriber DOB:	Patient Relationship to Subscriber:
Subscriber Employer:	Claims Address:	Carrier Phone:

The above information is true and correct. I understand that I am financially responsible for any charges, including balances not covered by my insurance. I will pay those balances due within 20 days of receipt of a statement. If collections become necessary, I will be responsible for any cost incurred.

Signature of Patient or Representative: _____ Date: _____

PATIENT HISTORY FORM

Patient Name	Date of Birth	Age	Gender	Referring Physician																									
Primary Reason for Your Visit Today: <input type="checkbox"/> Colon Cancer Screening <input type="checkbox"/> Other (Please Explain Briefly):																													
Have you had any of the following illnesses? <input type="checkbox"/> High blood pressure <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Taking Blood Thinners <input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal defibrillator (ICD) <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart valve disease <input type="checkbox"/> Stroke <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Cardiac Stent(s) <input type="checkbox"/> Chronic Kidney disease <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/Chronic bronchitis																													
Other Medical Problems: _____ _____																													
Prior Surgeries: ___ Colon/Bowel Resection ___ Gall Bladder ___ Abdominal Surgery ___ Hysterectomy ___ Hemorrhoid ___ Gastric Bypass/ Banding ___ Fundoplication Other: _____																													
Medications taken regularly and Dose (including over-the-counter & supplements): _____ _____																													
Drug allergies: ___ NO known Drug Allergies ___ Penicillin ___ Sulfa ___ Latex ___ Iodine Other: _____																													
Social History: Occupation _____ <input type="checkbox"/> Smoking: ___ pack(s)/day <input type="checkbox"/> Don't smoke <input type="checkbox"/> Marijuana Alcoholic beverages: <input type="checkbox"/> Don't drink <input type="checkbox"/> 1-5/week <input type="checkbox"/> 6-10/week <input type="checkbox"/> >10/week <input type="checkbox"/> Drug Use _____ Exercise: ___ # days/week Type of Activity: _____																													
Any Family History of: ___ Colon Cancer ___ Colon Polyp ___ Crohn's disease/Ulcerative colitis ___ Gastrointestinal/Biliary cancers ___ Other cancer(s): _____ ___ Other Gastrointestinal Diseases: _____																													
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%; text-align: center;"><u>Age(s)</u></th> <th style="width: 15%; text-align: center;"><u>Deceased</u></th> <th style="width: 55%; text-align: center;"><u>List Any Major Health Problems</u></th> </tr> </thead> <tbody> <tr> <td>Mother :</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Father:</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Siblings:</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Children:</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Others:</td> <td colspan="4">_____</td> </tr> </tbody> </table>						<u>Age(s)</u>	<u>Deceased</u>	<u>List Any Major Health Problems</u>	Mother :	_____	_____	_____	Father:	_____	_____	_____	Siblings:	_____	_____	_____	Children:	_____	_____	_____	Others:	_____			
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Siblings:	_____	_____	_____																										
Children:	_____	_____	_____																										
Others:	_____																												

Height: _____ Weight: _____

Review of Systems:

<p>General <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Chills <input type="checkbox"/> Fever</p> <p>Gastrointestinal (Digestive) <input type="checkbox"/> Poor appetite <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Pain with swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Regurgitation food <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> History peptic ulcer disease <input type="checkbox"/> Bloating <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Gallbladder surgery <input type="checkbox"/> Abdominal surgery <input type="checkbox"/> Liver disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Jaundice <input type="checkbox"/> Pancreatic disease <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Black colored stool <input type="checkbox"/> Diverticulosis <input type="checkbox"/> History of colon polyp/cancer <input type="checkbox"/> Blood in stool <input type="checkbox"/> Mucus in stool <input type="checkbox"/> Fecal incontinence <input type="checkbox"/> Anal pain or itching <input type="checkbox"/> Anal fissure</p>	<p>Respiratory <input type="checkbox"/> Frequent cough <input type="checkbox"/> Bloody sputum <input type="checkbox"/> Wheezing</p> <p>Cardiovascular <input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart attack <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur</p> <p>Locomotor/Musculoskeletal <input type="checkbox"/> Muscle pain/weakness <input type="checkbox"/> Joint pain /swelling <input type="checkbox"/> Back pain</p> <p>Genitourinary <input type="checkbox"/> Urinary burning sensation <input type="checkbox"/> Blood in urine</p> <p>Neuro-Psychiatric <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Substance Abuse</p> <p>Neck <input type="checkbox"/> Stiffness <input type="checkbox"/> Enlarged glands</p> <p>Other: _____</p>	<p>Head, Eyes, ears, Nose, Throat <input type="checkbox"/> Headache <input type="checkbox"/> Ear ache <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Sore Throat <input type="checkbox"/> Throat Clearing <input type="checkbox"/> Glaucoma</p> <p>Hematological <input type="checkbox"/> Slow to heal after the cuts <input type="checkbox"/> Anemia <input type="checkbox"/> Iron deficiency <input type="checkbox"/> Abnormal bruising <input type="checkbox"/> History of excessive bleeding after tooth extraction or surgery</p> <p>Endocrine <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Hot intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Diabetes</p> <p>Gynecological <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Abnormal vaginal bleeding <input type="checkbox"/> Heavy Menstrual periods <input type="checkbox"/> Menopause</p> <p>Skin <input type="checkbox"/> Tattoos <input type="checkbox"/> Rash, hives, eczema <input type="checkbox"/> Abnormal pigmentation</p>
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Preferred Pharmacy: _____
Name *Address* *Phone*

Patient Name (Printed) of Patient or Representative: _____

Signature of Patient or Representative: _____ Date: _____



FINANCIAL POLICY ACKNOWLEDGEMENT AND AGREEMENT

In this era of complex and often-confusing billing practices, we are committed to doing our part to help keep healthcare affordable and minimize unexpected expenses. Please read carefully. When you sign below you are acknowledging and agreeing to the following financial policies:

PATIENT COPAYMENTS

All applicable copays are required **at the time of service**. Our practice accepts **credit or debit card** payment only. We are no longer able to accept cash or check payments in the office.

APPOINTMENT NO-SHOW AND LATE CANCELLATION POLICY

Cancellations less than 3 business days prior to your office visit or less than 5 business days prior to your procedure are subject to a late cancellation/no-show fee: \$100-\$150 for office appointments and \$250-\$500 for procedures (based upon the type of appointment cancelled/missed) This may be billed to your account.

PAYMENTS AND COLLECTIONS

We bill **participating** insurance companies. The patient is financially responsible for any services provided including any balances not covered by insurance. The patient agrees to pay those balances due within 20 days of receipt of a statement. Late payments are subject to a monthly fee on unpaid balances. Balances not paid within 45 days of receipt of a statement are subject to collections. If collections become necessary, the patient will be responsible for any cost incurred. **Any questions regarding billing may be directed to (925) 624-3424**

1. I understand and agree to all financial policies listed above.
2. I authorize disclosure of my personal health information (PHI) to the extent necessary for insurance, billing and treatment purposes.
3. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance and any other insurance plan.
4. I understand I am financially responsible for all charges not paid by said insurance company, including any deductibles, copays and co-insurance, and that copays are due at the time of services.

Patient Name or Representative (Printed) : _____

Signature of Patient or Representative: _____ Date: _____



BILLING CATEGORY ASSIGNMENT OF BENEFITS FORM

During the course of your evaluation and treatment, physicians and professionals outside of BASS Medical Group may be involved in your care. Following a procedure, such as endoscopy or colonoscopy, it is common to be billed for physician services, anesthesia services, pathology services (if a biopsy was taken) and facility fees. **Each entity will bill separately for services provided.** You are free to utilize any health care facility or provider of your choice, subject to the restrictions of your physician’s affiliation or restrictions which may exist under your health insurance coverage.

Patients should check with their health insurance provider if they have any questions or concerns about their coverage.

BASS Medical Group and Affiliated Organizations*

<u>Physician Billing</u>	<u>Facility Billing</u> <i>(one of the following)</i>	<u>Anesthesia Billing</u>	<u>Pathology Billing</u> <i>(one of the following)</i>
BASS MEDICAL GROUP	SHADELANDS ADVANCED ENDOSCOPY INSTITUTE ASPEN SURGERY CENTER JOHN MUIR MEDICAL CENTER	MEDICAL ANESTHESIA CONSULTANTS	PRECISION PATHOLOGY CONTRA COSTA PATHOLOGY ASSOCIATES ASSOCIATED PATHOLOGY MEDICAL GROUP

*Affiliated Organizations are subject to change without prior notification

1. I understand that the companies above will disclose my personal health information (PHI) for insurance and treatment purposes only. I am allowing the release of all PHI necessary for payment and treatment of my specific health problem.
2. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance and any other insurance plan. Billing from the facility, anesthesiologist or pathologist will be handled separately by those entities.
3. I understand I am financially responsible for all charges not paid by said insurance company, including any deductibles, copays and co-insurance, and that copays are due at the time of services.

Patient Name or Representative (Printed) : _____

Signature of Patient or Representative: _____ Date: _____



Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

We are dedicated to maintaining the privacy of your protected health information. Federal and state laws ensure the privacy of your medical records, their availability to you, and specific rights regarding your medical records. In addition to your authorization, we may use or disclose your health information in accordance with the law under certain circumstances. Please refer to our full HIPAA Notice of Privacy Practices for all potential general use and disclosures.

I UNDERSTAND MY RIGHTS TO:

Revoke or change the authorization below at any time. (Please note, revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the notice to revoke). I may also inspect or copy my protected health information to be disclosed as described in this document. I understand that if the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

DISCLOSURE AND RELEASE OF PAPER OR ELECTRONIC RECORDS:

Voicemails:

_____ I **DO NOT** authorize the disclosure or release of my protected health information to any
Initial person/entity or via a message left on a **voicemail**.

or

_____ I **DO** authorize the physicians and staff of the practice to disclose health information regarding
Initial appointments, labs bills or other general patient communication via **voicemail** on the following telephone numbers:

Telephone #: _____ Telephone #: _____

Disclosure to Others:

_____ I **DO NOT** authorize disclosing or releasing information about my care to ANY family or friends
Initial

or

_____ I **DO** authorize that information about my care may be disclosed or released to (e.g. to family
Initial member or close friend):

Name _____ Relationship to Patient: _____

Name _____ Relationship to Patient: _____

Patient Name (Printed) of Patient or Representative: _____

Signature of Patient or Representative: _____ Date: _____



ACKNOWLEDGEMENT OF PRIVACY PRACTICES

We are dedicated to maintaining the privacy of your protected health information (PHI.) Federal and state laws ensure the privacy of your medical records, their availability to you, and specific rights regarding your medical records. In addition to your authorization, we may use or disclose your health information in accordance with the law under certain circumstances.

In an effort to reduce excess use of paper, the complete patient privacy practices notice is available online at www.californiadigestivecare.com. Below is a summary of how we collect, use, communicate, disclose and make use of personal information.

Outline of Our Privacy Policy:

- Before or at the time of collecting personal information, we will identify the purposes for which the information is being collected.
- We will collect and use personal information solely with the objective of fulfilling those purposes specified by us and for other comparable purposes, unless we obtain the consent of the individual concerned as required by law.
- We will only retain personal information as long as necessary for the fulfillment of those purposes
- We will collect personal information by lawful and fair means and, where appropriate, with the knowledge or consent of the individual concerned
- Personal data should be relevant to the purposes for which it is to be used, and, to the extent necessary for those purposes, should be accurate, complete, and up-to-date.
- We will protect personal information by reasonable security safeguards against loss or theft, as well as unauthorized access, disclosure, copying, use or modification.
- We will make readily available to customers information about our policies and practices relating to the management of personal information

I have carefully read, understand, and agree with California Digestive Care's **Complete** Patient Privacy Agreement, not only the summary included here. I understand that I may obtain a copy online any time at: www.californiadigestivecare.com. I understand that a paper copy is also available to me upon request the next time I receive services at one of their offices or by contacting the office directly at (925) 322-2372 to have a written copy mailed to me.

Patient Name (Printed) of Patient or Representative: _____

Signature of Patient or Representative: _____ Date: _____

Please choose 1 of the following:

____ I DO wish to receive a printed copy of the complete patient privacy practices notice at this time.

____ I DO NOT wish to receive a printed copy of the complete patient privacy practices notice at this time.