Delaware Center for Digestive Care
GASTROENTEROLOGY AND HEPATOLOGY

PERSONAL HISTORY FORM

Patient Name: _____Date: _____
Date of birth: _____ Sex: □ M □ F Occupation: _____

Who has referred you to our practice? _____
Please described the reason for your referral or list your current symptoms: _____
_____
_____

Have you ever had an endoscopy and/or colonoscopy? If so, when and by whom? _____
_____

Please list current medications or provide a list to the Medical Assistant:

Name	Dosage	How often	Name	Dosage	How often
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you had any of the following medical conditions:

□ High blood pressure □ Cancer □ Colon polyps □ Blood Transfusion
□ Diabetes disorder □ Bleeding or clotting □ Colon Cancer □ Spine/Joint problem
□ Heart Disease □ HIV □ Hepatitis/Jaundice □ Asthma/emphysema
□ Seizure or Stroke □ Kidney or Bladder □ Gallbladder disease □ Other: _____
□ Lung Disease □ Anxiety/Depression/Bipolar □ Diverticulitis

Drug Allergies: (Please list and describe)

Drug	**Reaction**	**Drug**	**Reaction**
1. _____			
2. _____			
3. _____			

Please list all prior surgeries and dates:

1. _____
2. _____
3. _____

List other hospitalizations: _____
_____

Social Habits:

Do you smoke? □ Now □ Previously _____packs/day for _____years

Do you drink alcohol? □ Now □ Previously How much per day/week? _____

Have you ever used recreational drugs? What, when and how often? _____

Family History:

Do you have a family history (parents and/or siblings) of: (Please check) If so, whom?_____

□ Colon cancer _____ □ Colon polyps _____ □ UC/ Crohn's _____

□ Celiac disease _____ □ Pancreas Cancer _____ □ Any Genetic illness _____

□ Pancreas cancer _____ □ Bile duct cancer _____ □ Other GI Illness _____

□ Liver cancer _____ □ Uterine cancer _____ □ Other Cancer _____

DO YOU PRESENTLY HAVE (Please check):

Constitutional: □ Recent weight change □ Fatigue □ Fever □Weight

Eyes: □ Double vision □ Glaucoma □ Cataracts □ Vision Loss

Ears, nose, mouth, throat: □ Ringing in ears □ Dizziness □ Hearing loss □ Nosebleeds
□ Sinus trouble □ Bleeding gums □ Hoarseness

Cardiovascular: □ Heart murmur □ Chest pains □ Palpitations
□ Leg pains with walking □ Shortness of breath □ Phlebitis

Respiratory: □ Cough □ Cough up blood □ Pain with breathing

Gastrointestinal: □ Trouble swallowing □ Nausea □ Vomiting □ Blood in stools
□ Diarrhea □ Constipation □ Black stools □ Abdominal pain

Genitourinary: □ Frequent urination □ Painful urination □ Blood in urine □ Incontinence

Musculoskeletal: □ Muscle or joint pain □ Arthritis □ Gout

Skin: □Rashes □ Sores □ Itching

Psychiatric: □ Depression □ Anxiety □ History of psychiatric problems

Endocrine: □ Thyroid trouble □ Heat or cold intolerance □ Excess thirst or hunger

Hematologic: □ Anemia □ Swollen glands

Men: □Penile discharge □ Testicular pain or masses

Women: □ Irregular menstrual periods □ Possible pregnancy

Is there anything else your physician should be aware of at your visit:

_____

_____

_____

_____

_____

Delaware Center for Digestive Care
GASTROENTEROLOGY AND HEPATOLOGY

Mid-Atlantic G.I. Consultants P.A. Division (302) 225-2380
Gastroenterology Associates P.A. Division (302) 738-5300

STATEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge that Delaware Center for Digestive Care may bill my insurance as a courtesy to me, but the financial responsibility for any and all charges incurred during my treatment is mine. In consideration of the services rendered, I promise to pay DCDC the full amount of charges for said services upon demand or in accordance with payment arrangements agreed by them. I consent to permit DCDC as with other institutions that extend credit, to access my credit report through a national credit agency, and to use this information in determining the method, timing, and amount of any payments. If I fail to keep this promise, I understand that I will also be responsible for paying the costs of collection.

I understand that if I do not pay the patient due balance in a timely manner and must be sent to a collections agency, that thirty five percent of my outstanding balance will be added to the amount due to cover the costs of collections. I agree to pay this cost in addition to the outstanding balance for services rendered.
Failure to cancel or no show for your appointment may lead to an administrative fee.

Signature of Patient, Guardian, or Authorized Representative Date

ASSIGNMENT OF INSURANCE BENEFITS

PATIENTS NAME:_____ DATE:_____

I hereby request that any and all benefits otherwise due me for services rendered by DCDC be assigned and paid to DCDC

Insured Person's Signature

ASSIGNMENT OF MEDICARE BENEFITS

MEDICARE NUMBER

I request that payment of Medicare Benefits for services rendered to me by DCDC be made directly to DCDC.

Signature
DCDC Medicare signature on file

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected health information may be used and disclosed by DCDC to carry out treatment, payment and health care operations. Please see DCDC notice about uses disclosures of information described in this Consent. You have the right to review the Notice before signing this Consent. DCDC has reserved the right to change their privacy practices and that I can obtain such changed notice upon request. I consent to DCDC to release protected health information of:

Patient:_____ Date of Birth:_____

I understand that signing this Consent authorizes DCDC to release protected health information including but not limited to, any information acquired over the course of my examination and/or treatment and information needed to determine benefits or benefits payable for related services to: (1) my insurance company; (2)Centers for Medicare and Medicaid Services ("CMS formerly known as HCFA"); or (3) any healthcare may refuse further treatment if I do not sign this Consent or if I revoke this Consent. I understand that I may revoke this Consent at any time, in writing, but my revocation will not be effective as to any consent DCDC has relied upon. I understand that I have the right to request restrictions on DCDC uses and disclosures of protected health information, even though DCDC does not necessarily have to agree to my requested restrictions.

Signature of Patient, Guardian, Or Authorized Representative Date

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Notice of Privacy Practice Acknowledgement

I acknowledge that I have been provided with and have had an opportunity to read a copy of the Notice of Privacy Practice for Delaware Center for Digestive Care.

Patient Name Date of Birth

Signature (Guardian, Parent, Responsible Party of above patient) Date

☐ You may discuss my condition/results with: _____

Relationship: _____

☐ You may not discuss my condition/results with anyone.

☐ You may leave messages concerning test results, appointments, my condition and diagnosis on my home voice mail, cell phone voice mail or personal e-mail.

E-mail address: _____

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Compliance Officer in person or by phone at 302-830-DCDC.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.