DIGESTIVE DISEASE SPECIALISTS, INC.
INSTITUTE OF DIGESTIVE DISEASE
DDSI AEC SOUTH LLC

PATIENT INFORMATION

DATE: _____

FULL LEGAL NAME (No Nicknames)

DDSI PROVIDER: _____

☐ MR. ☐ MRS. ☐ MS. ☐ MISS

LAST NAME_____FIRST_____MI____ PREFERRED NAME_____

DATE OF BIRTH_____ AGE_____ SEX (circle one) M F SOCIAL SECURITY NUMBER_____

PATIENT RACE ☐ Amer. Indian/Alaskan ☐ Asian ☐ Black/African Amer. ☐ Nat. Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other ☐ Declined

PATIENT ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Other_____

MARITAL STATUS ☐ Single ☐ Married ☐ Life Partner ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Declined

ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE_____ BUSINESS PHONE_____ CELL PHONE_____ FAX NUMBER _____

(WHICH IS THE BEST NUMBER TO REACH YOU? ☐ HOME ☐ CELL ☐ BUSINESS)

EMAIL_____

PATIENT'S EMPLOYER_____ PATIENT'S POSITION_____

BUSINESS ADDRESS_____

SPOUSE'S NAME_____ SPOUSE'S EMPLOYER_____

SPOUSE'S WORK PHONE_____SPOUSE'S CELL PHONE_____

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)

NAME_____ RELATIONSHIP_____

(IF OTHER THAN PATIENT)

ADDRESS_____

HOME PHONE NUMBER_____ CELL PHONE NUMBER_____

EMPLOYER_____ POSITION_____

BUSINESS ADDRESS_____ BUSINESS PHONE_____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY (OTHER THAN SPOUSE)

NAME_____ RELATIONSHIP_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

PREFERRED METHOD OF COMMUNICATION

☐ HOME PHONE ☐ CELL PHONE ☐ MAIL ☐ PATIENT PORTAL

PREFERRED PHARMACY

1. LOCAL PHARMACY – NAME, ADDRESS, PHONE, FAX_____
2. MAIL IN PHARMACY – NAME, ADDRESS, PHONE, FAX_____

INSURANCE INFORMATION (PLEASE BRING INSURANCE CARDS AT TIME OF SERVICE)

NOTICE: IF YOU'RE A CURRENT HOSPICE PATIENT PLEASE CHECK BOX ☐

PRIMARY INSURANCE

POLICY HOLDER_____ DOB_____ SS#_____

INSURANCE COMPANY_____ GROUP #_____ POLICY #_____

INS CO ADDRESS_____ TELEPHONE #_____

POLICY HOLDER'S EMPLOYER/PHONE #_____

SECONDARY INSURANCE

POLICY HOLDER_____ DOB_____ SS#_____

INSURANCE COMPANY_____ GROUP #_____ POLICY #_____

INS CO ADDRESS_____ TELEPHONE #_____

POLICY HOLDER'S EMPLOYER/PHONE #_____

REFERRAL SOURCE

REFERRED BY (circle one): PROVIDER (NAME)_____ FRIEND; FAMILY; ACQUAINTED WITH PROVIDER; ACQUAINTED WITH STAFF; YELLOW PAGES; HEALTH PLAN; REFERRAL SERVICE; OTHER_____

DIGESTIVE DISEASE SPECIALISTS, INC
.(Institute of Digestive Disease Specialists, Inc, DDSI South AEC, LLC, Digestive Disease Pathology, LLC)

PATIENT INSURANCE and FINANCIAL POLICY

Thank you for choosing us for your health care. Our AECs and offices are privately owned by the physicians of Digestive Disease Specialists, Inc. (DDSI). The information below outlines our financial policies and expectations in regard to payment for services provided to you by DDSI. If you have any questions about these policies, please contact Business Services at 405-767-6630.

IF YOU HAVE INSURANCE: Please bring/present all health insurance cards or policy information with you at the time of service. If this information is not provided, your account will be set up as uninsured and payment in full will be expected at the time of service.

- It is your responsibility to check with your insurance plan regarding any co-payment, deductible or co-insurance you might owe at the time of service. All non-covered services an denials may be the responsibility of the patient if applicable.
- Insurance claims are filed as a courtesy. It is your responsibility to see that the claims are paid.
- Our insurance verification team will check benefits, co-pays and deductibles for any procedure scheduled at our endoscopy centers. You should receive a telephone call from the verification team a few days prior to your procedure (time permitting).
- We cannot guarantee payment by your insurance company and all quotes given are estimates. Co-pays and deductibles could change once the claim is processed by your insurance company, depending on your plan's details and the physician's final diagnosis.

IF YOU DO NOT HAVE INSURANCE: Payment in full is expected prior to services rendered**. Exception**: Extenuating circumstances may require that a payment plan be set prior to services rendered. .

ALL PATIENTS (please initial each section)

- ___ **FORMS OF PAYMENT:** DDSI accepts checks, cash, Visa, MasterCard, Discover, American Express, Debit Cards, Health Saving and Online Bill pay by accessing our website www.okddsi.net (Resource: Pay My Bill). For assistance with either, you may contact the Business Services 405-767-6630. We also offer recurring payment options and financing through Care Credit.
- ___ **RETURNED CHECKS:** A $35.00 charge will be added to your account for any check returned by your bank for any reason. This will be in addition to charges made by your bank. DDSI cooperates with the Oklahoma County District Attorney's Office to prosecute bad check writers. (Any amount less than $50 is considered a misdemeanor and amounts exceeding $50 is considered a felony)
- ___ **NO SHOW/CANCELLATION/RESCHEDULES:** We have reserved time and resources, just for you. Thank you for understanding that without sufficient time to refill your appointment, valuable medical resources are wasted, and cannot be recovered. Not providing our office with a minimum of 48 hours advanced notice of your intent to **cancel,** or **not show** for an office visit, will result in a $50.00 surcharge to your account. Not providing our office with a minimum of 72 hours advanced notice of your intent to **cancel** or **not show** for a procedure, will result in a $200.00 surcharge to your account.
- ___ **SCREENING PROCEDURES**: If you are scheduled for a procedure: the facility submits procedural documentation and charges according to Centers for Medicare and Medicaid Services guidelines and is not responsible for determining how your benefits will be paid. Please keep in mind that ALL charges may not be covered under your screening and health preventive benefits.
- ___ **WORK COMP:** We will file your work comp claim provided we have received authorization from your adjuster. NOTE: If you notify our office that your injury is work related, we will NOT file your health insurance.
- ___ **PATIENT CREDITS:** Overpayments may occasionally result in a credit balance on a patient account. DDSI issues a refund check to the patient for any credit balance in excess of $9.99 and upon the patient's request if less than $9.99. (Note: Credits created by use of a credit card will require credit applied back to that card)

For billing purposes, there could be four (4) separate service components which will be billed:

- **Professional Component**…physician's professional services that are provided during your procedure.
- **Facility Component**…facility fee for the use of the Ambulatory Endoscopy Center in which your procedure is being performed.
- **Pathology Component**….If biopsy's taken you may receive a bill for pathology
- **Anesthesia Component**….DDSI provides a higher level of sedation known as monitored anesthesia care in which we use 'Propofol'.

YOU ARE ENTERING INTO A FINANCIAL CONTRACT BETWEEN YOURSELF AND OUR COMPANY

The following statements apply to this financial agreement:

- I understand that responsibility for payment of medical services in this office/endoscopy center for myself and my dependents is mine. Co-pays and deductibles are due and payable at the time services are rendered unless financial arrangements have been made in advance with our Business Office.
- I understand that any co-insurance and/or deductible incurred, after my insurance company processes claims for services provided, is expected within 30 days of the first statement date.
- I understand if my account is not paid in full within 30 days of my first statement and payment arrangements are not set up, collection proceedings will begin. We utilize collection agencies for past due/unpaid accounts.
    - I understand if I have an unpaid balance at DDSI and do not make acceptable payment arrangements to bring my account current, my account will be placed with an external collection agency. I further understand I will reimburse DDSI the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable attorney fees, that DDSI incurs in such collection efforts. This will be assessed to my account and included in the balance due. Finally, I understand this will result in endangering my credit rating on a local and/or national level by being reported to all three-credit bureau's (Equifax, TransUnion and Experian).
    - I authorize DDSI to contact me via current and any future cellular phone number(s), email address(es), or wireless device(s) regarding my delinquent account, any debt I owe to DDSI or to receive general information from DDSI. I authorize DDSI and its agents, representatives, and attorney's (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account financial obligation which is past due.
- DDSI may disclose any or all of the patient's information for insurance claim purposes. If some other party is paying the patient's bill or by any contract may be expected to pay the bill, then DDSI may disclose any or all of the patient's information to that party to verify charges. DDSI may disclose any or all of the patient's information to all health care providers who have a legitimate need for such information which indicates the presence of a communicable or venereal disease (such as Hepatitis, Syphilis, gonorrhea, HIV also known as AIDS) and/or presence of alcoholism, drug abuse and mental health problems. I authorize release of all information from DDSI for these purposes.

I have read, understand and agree to the provisions of this Insurance and Financial Policy Form (refusal to sign will result in patient not seen).

_____ _____

Signature of Patient or Responsible Party Date

Photostat of the above is as valid as the original. **12/2017**

DIGESTIVE DISEASE SPECIALISTS, INC.

OFFICE

RECEIPT OF PRIVACY NOTICE AND PATIENT RIGHTS & RESPONSIBILITIES

Patient Name (Please Print) _____ Date of Birth _____

_____ Patient Initial — I have been given a copy of the Digestive Disease Specialists, Inc. (DDSI) Privacy Notice, and understand that I may request a copy of this notice at any time.

_____ Patient Initial — I have received a copy of the Digestive Disease Specialists, Inc. Patient Rights and Responsibilities form.

_____ Patient Initial — I have received a copy of the Oklahoma State Department of Health's brochure regarding "Your Medical Treatment Rights Under Oklahoma Law"

USE AND DISCLOSURE AGREEMENT

You have the right to restrict or limit the personal health information we disclose about you to someone else, and to specify the way in which we communicate with you about your medical issues.

Please indicate your preference below:

The following people may receive information about me: **OR** I do **NOT** want you to speak with anyone else about my health issues. ☐

NAME	RELATIONSHIP

PREFERRED COMMUNICATION METHOD AND AUTHORIZATION TO LEAVE MESSAGES

☐ HOME PHONE #_____ ☐ CELL PHONE #_____ ☐ MAIL ☐ PATIENT PORTAL

☐ Yes, DDSI MAY leave a message on my answering machine/voice mail regarding my Protected Health Information.
☐ No, DDSI MAY NOT leave a message on my answering machine/voice mail regarding my Protected Health Information.

I understand that if I change my mind about any of the information on this form, I must contact Digestive Disease Specialists, Inc. to revoke this form in its entirety, or to complete a new form. Otherwise, this form will remain in effect for a period of two years.

Patient Signature _____ Today's Date _____

Digestive Disease Specialists, Inc. ***DDSI South AEC, LLC***

Advance Directive Policy

As a patient, you have the right to participate in your own health care decisions.

Digestive Disease Specialists, Inc. and DDSI South AEC, LLC recognizes these rights.

However, it is our policy that if an unexpected event occurs during your procedure, we will start CPR and EMSA will transfer you to the nearest Emergency Room for care.

When you come for a procedure, you will be asked to sign an "Agreement for Resuscitation" Form.

If you do not sign the agreement form, your procedure will need to be rescheduled at another facility.

Thank you for your cooperation.

Digestive Disease Specialists, Inc.
DDSI South AEC, L.L.C.
PATIENT HISTORY INTAKE FORM

PATIENT NAME: **Gender: F / M Age:** **DOB:** **Date:**

Marital Status: Single Married Life Partner Divorced Widow / Widower **Who lives with you?**

Occupation: **Referring Physician:**

Chief Complaint/ WHY ARE YOU HERE: **Have you been treated for this before? YES / NO**

ALLERGIES to *DRUGS / FOODS / MATERIALS:* **[ ] NO KNOWN ALLERGIES**

Females: Are you now (or could you be) pregnant?: Yes No Unknown N/A Date of LMP:

REVIEW OF SYSTEMS: **Please Answer ALL questions Yes or No to the conditions you presently have or have had in the past year.**

General	Fever	Yes / No
	Fatigue	Yes / No
	Weight loss	Yes / No
	How much have you lost?	
ENT	Eye Problems	Yes / No
	Glaucoma	Yes / No
	Hearing Difficulty	Yes / No
	Throat problems	Yes / No
	Mouth sores	Yes / No
Heart and Circulation	Chest Pain	Yes / No
	High blood pressure	Yes / No
	Congestive Heart Failure	Yes / No
	Heart Attack	
	Dates:	
	Heart Murmur	Yes / No
	Heart valve disease	Yes / No
	Heart valve replacement	Yes / No
	Type:	
	Pacemaker	Yes / No
	Type:	
	Defibrillator	Yes / No
	Date/Type:	
Lung	Asthma	Yes / No
	Emphysema / COPD	Yes / No
	Tuberculosis	Yes / No
	Shortness of Breath	Yes / No
Neuro	Seizure Disorder	Yes / No
	Stroke	Yes / No
	Dates:	
Musculo skeletal	Arthritis	Yes / No
	Back / Neck Pain	Yes / No
	Muscle / Joint Pain	Yes / No
GU	Frequent Urination	Yes / No
	Blood in Urine	Yes / No
	Kidney Stones	Yes / No
	Renal Failure	Yes / No
	Prostate Problems	Yes / No
	Menstrual Problems	Yes / No

Endo-crine	Thyroid Disease	Yes / No
	Pancreas Disease	Yes / No
	Diabetes (Insulin or Meds)	Yes / No
Hematologic/ Lymphatic	**Anemia (Low blood count)**	Yes / No
	Bleed / bruise easily	Yes / No
	Bleeding Disorders	Yes / No
	Enlarged glands	Yes / No
	HIV / AIDS	Yes / No
	Cancer	Yes / No
	Type:	
Skin	Eczema, Hives, Rash	Yes / No
Gastrointestinal / Liver	Abdominal pain / cramps	Yes / No
	Heartburn / Indigestion	Yes / No
	Bloating / Early Fullness	Yes / No
	Nausea / Vomiting	Yes / No
	Vomiting blood	Yes / No
	Loss of appetite	Yes / No
	Difficulty swallowing	Yes / No
	Stomach Ulcers	Yes / No
	Hepatitis / Type _____	Yes / No
	Cirrhosis of the Liver	Yes / No
	Jaundice	Yes / No
	Abnormal Liver Tests	Yes / No
	Change in Bowel Habits	Yes / No
	Constipation-persistent	Yes / No
	Diarrhea	Yes / No
	Black / Bloody Stools	Yes / No
	Hemorrhoids	Yes / No
	Crohn's Disease	Yes / No
	Ulcerative Colitis	Yes / No
	History of Colon Polyps	Yes / No
	Colonoscopy in past	Yes / No
	Dates:	
	EGD in past	Yes / No
	Dates:	
Mental Health	Depression	Yes / No
	Anxiety Disorder	Yes / No
	Alcoholism	Yes / No
	Substance Abuse	Yes / No

LIST ALL MEDICATIONS / SUPPLEMENTS / ASPIRIN & BLOOD THINNERS

[ ] NSAIDs - Aleve, Advil, Celebrex, Ibuprofen, Motrin, Naproxen, others - *please list*.

LIST NAME / DOSE / FREQUENCY / LAST TAKEN

[ ] See Attached List

PLEASE LIST ALL PREVIOUS MAJOR ILLNESSES / HOSPITALIZATIONS / SURGERIES AND DATES

Do you have an Advance Directive? YES / NO
If not, would you like more information about one?
YES NO

NOTES:

FAMILY HISTORY-LIST Parents (M or F),Brothers (B),Sisters (S), Children (C) **[ ] Adopted or no known family history**

Breast Cancer
Colon / Rectal Cancer
Colon Polyps
Stomach Cancer
Other GI Diseases
Crohn's Disease
Ulcerative Colitis
Ulcers
Gallstones

	Number/ Age (s) If not living age of death	Significant Diseases / Cause of Death
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

SOCIAL HISTORY: Please answer ALL questions

Weight History
Present Weight
Usual Weight
Change in past year _____

Education-Completed
Grade school
High School
Vocational
College

Smoking
Pipe / Cigar / Vape / Chew--Amt? _____
Cigarettes--Packs per day? _____
Age started _____ Age quit _____
Recreational Drugs

Alcohol
Never Occasional Heavy
Amount per week?
Type / Amt per day?
Alcoholic? When did you quit?

GENERAL HEALTH *(circle response)*

Have you had the pneumonia vaccine in the past 10 years?	Yes	No
Have you traveled outside the USA in the past 3 months?	Yes	No
Have you fallen in the past year?	Yes	No

PATIENT SIGNATURE: **DATE:**