Digestive Health Specialists, P.A

STAFF USE ONLY

Physician: _____

Ht._____ Wt._____ BP _____

Side I

MEDICAL HISTORY QUESTIONNAIRE

Information to Become Part of Your Confidential Medical Records

PLEASE PRINT

First	Middle	Last	Age:	Sex:	Religion:
NAME:					

Date of Birth:	REFERRING PHYSICIAN:	Date of last Colonoscopy_____ EGD (Gastroscope) _____

REASON FOR VISIT

☐ Other *(Describe)*

WEIGHT HISTORY

Present Height
_____ft._____in.

Weight Changes During Past Year?
Gained_____lbs.
Lost_____lbs.

Tattoos: ☐Yes ☐No
Body Piercing: ☐Yes ☐No

HABIT HISTORY

SMOKING:

Pipe _____ Pipe _____
Cigar _____ Cigar _____
Chew _____ Chew _____

ALCOHOL:

Never_____ Occasional _____
Moderate_____ Heavy _____

(✓) Check Know Allergies or Reaction to Medications Below. (List Any Not Shown)

	Penicillin
	Sulfa
	Antibiotics
	Sedatives
	X-Ray / Dyes
	Others:
	PHARMACY NAME:

LIST MEDICATIONS / DRUGS TAKEN OVER PAST 6 MONTHS

Medications / Drugs		How Long Taken?	Stop Taking?

PLEASE INDICATE PREVIOUS MAJOR ILLNESSES, SURGERY OR INJURY

Define Problem	Where Did It Happen?	Year	Difficulties Now?

FAMILY HISTORY

Parents	Age if Living	Age at Death	Present Condition or Cause of Death?
Father			
Mother			

Number of Brothers _____
Number of Sisters _____
Children: Number _____ Ages _____

Has anyone in your immediate family (Father, Mother, Brothers or Sisters) had any of the medical problems listed below? *If yes, Who?*

☐ Cancer _____
☐ Colon Cancer ☐ Colon Polyps ☐ Other
☐ Ulcers _____
☐ Diabetes _____
☐ Asthma _____
☐ Inflammatory Bowel Disease _____
☐ Thyroid Trouble _____

☐ Suicide _____
☐ Mental Illness _____
☐ Stroke _____
☐ Heart Trouble _____
☐ High Blood Pressure _____
☐ Bleeding Tendency _____
☐ Other *(Describe)* _____

Side II

PAST HISTORY: (✓) CHECK BELOW ANY PROBLEMS YOU HAVE NOW - OR THAT YOU HAVE HAD IN THE PAST.

☐ ASTHMA	☐ CIRRHOSIS	☐ DIABETES
☐ PNEUMONIA	☐ HEPATITIS	☐ KIDNEY STONE
☐ TUBERCULOSIS	☐ ULCERS	☐ SKIN PROBLEMS
☐ HEART TROUBLE	☐ PANCREATITIS	
☐ RHEUMATIC FEVER	☐ GALLBLADDER PROBLEMS	

REVIEW OF SYSTEMS: Please answer yes or no to the following:

Constitutional		
Y	Appetite Change	N
Y	Chills	N
Y	Fever	N
Y	Night Sweats	N
Y	Unexpected Weightt Change	N

HENT		
Y	Mouth Sores	N
Y	Nosebleeds	N
Y	Sore Throat	N
Y	Trouble Swallowing	N
Y	Hearing Loss	N

Respiratory		
Y	Cough	N
Y	Choking	N
Y	Chest Tightness	N
Y	Shortness of Breath	N
Y	Wheezing	N
Y	Dyspnea at rest	N

Cardiovascular		
Y	Chest Pain	N
Y	Dyspnea on exertion	N
Y	Palpitations	N
Y	Orthopnea	N
Y	Leg Swelling	N

Gastrointestinal		
Y	Abdominal Distention	N
Y	Abdominal Pain	N
Y	Anal Bleeding	N
Y	Blood in Stool	N
Y	Change in Bowel Habit	N
Y	Constipation, Diarrhea	N
Y	Heartburn	N
Y	Vomiting Blood	N
Y	Hemorrhoids	N
Y	Nausea	N
Y	Rectal Pain	N
Y	Vomiting	N
Y	Black Tarry Stools	N
Y	Dysphagia with liquids	N
Y	Dysphagia with solids	N
Y	Fecal Incontinence	N
Y	Stool Pattern Pain	N

Genitourinary		
Y	Decreased Urine Volume	N
Y	Difficulty Urinating	N
Y	Dysuria	N
Y	Flank Pain	N
Y	Frequency	N
Y	Hematuria	N
Y	Urgency	N

Musculoskeletal		
Y	Arthralgias	N
Y	Back Pain	N
Y	Joint Swelling	N
Y	Myalgias	N

Skin		
Y	Color Change	N
Y	Itching	N
Y	Rash	N
Y	Jaundice	N

Neurological		
Y	Dizziness	N
Y	Vertigo	N
Y	Speech Difficulty	N
Y	Seizures	N
Y	Weakness	N
Y	Headaches	N
Y	Excessive daytime sleepiness	N

Psychiatric / Behavioral		
Y	Agitation	N
Y	Confusion	N
Y	Sleep Disturbance	N
Y	Nervous/Anxious	N

Hematological		
Y	Adenopathy	N
Y	Bruise/Bleed Easily	N

Endocrine		
Y	Cold Intolerance	N
Y	Heat Intolerance	N
Y	Polydipsia	N

Allergic / Immunologic		
Y	Environmental Allergies	N
Y	Food Allergies	N
Y	Immunocompromised State	N

Patient Registration Form

Digestive Health Specialists, P.A

Patient Information

Patient Information

Last Name:	First Name	M.I.:	Date of Birth:
Mailing Address:		Apt #	
City/State/Zip:			
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widow	Sex: ❑ Male ❑ Female	Social Security #:	
Home Phone:	Cell Phone:	Email:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ❑ Voice ❑ Text		If Voice, Please Select Preferred Number: ❑ Home ❑ Cell	
Employer Name:	Employer Phone Number:		
Emergency Contact Name:			
Emergency Contact Phone #:	Relationship to Patient:		

Race (please select):
❑ White ❑ American Indian or Alaska Native ❑ Asian
❑ Hispanic ❑ Black or African American ❑ Native Hawaiian or Pacific Islander
❑ Other ❑ Decline

Ethnicity (please select one):
❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Decline

Preferred Language (please select one):
❑ English ❑ Spanish ❑ Chinese
❑ Sign Language ❑ Japanese ❑ Other

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security # and Insurance ID #:	Policy Holder's Social Security # and Insurance ID #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Digestive Health Specialists' (DHS) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to DHS all money to which I am entitled for medical expenses related to the services performed from time to time by DHS, but not to exceed my indebtedness to DHS. I authorize DHS to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from DHS by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to DHS. I authorize any holder of medical information about me to release to DHS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Digestive Health Specialists' Privacy Notice. ☐ **(Initials)**

Signature of Patient or Responsible Party: X_____ **Date:** _____

Printed Name of Patient or Responsible Party: X_____ **Date:** _____

Digestive Health Specialists, P.A.

Thank you for choosing Digestive Health Specialists, PA (DHS) for your gastroenterology healthcare needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding general practice guidelines and patient financial responsibility for services rendered, we have developed these policies for your information and future reference. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

The DHS website offers helpful information and options for all patients at www.dhsgi.net. Please be sure to ask the receptionist for a PIN to access the North Mississippi Medical Center Patient Portal. This is where all of your electronic health information is stored.

Practice Policies

Telephone Calls. The automated phone tree will assist in getting your call to the appropriate party more quickly. The following options will be available when your call in answered:

1) Physician or hospital referrals (typically new patients)
2) Scheduling or rescheduling appointments or procedures
3) Billing or Insurance
4) Test results or if you need to speak to the clinical staff directly
5) All other calls

All calls will be returned in the order they are received. Generally, all calls received before lunch will be returned before the afternoon session begins and all calls received by 3:00pm will be returned by the end of the day. All other calls will be returned the next business day.

Medication Refills. As a general rule, if your prescription has run out of authorized refills, you will be required to make an appointment for a prescription renewal. All refills and renewals should be initiated through your pharmacy. There is no need to call the office to renew regular medications prescribed by a DHS provider. Please notify your pharmacy when you need a refill and they will contact our office for approval. We request 72 hours (business hours) to process all prescription refills.

Missed appointments. Because of the high demand for appointments, an accurate schedule is very important. We feel strongly that every appointment is medically necessary to ensure the best outcome for our patients. Please help us to serve you and all other patients better by keeping your appointments as scheduled. We will provide appointment reminders by phone or email 48-72 hours prior to your appointment. Please ensure that your contact information and preferred method of contact is updated with the front desk staff and respond to these calls according to the instructions.

In the event that an appointment is missed without at least 24 hour notice of cancellation, it is our policy to charge for missed appointments ($25.00 for an office visit, $50.00 for procedures). These charges are patient responsibility and billed directly to you. Repeated no show incidents may result in dismissal from the practice as this non-compliance with recommended medical care jeopardizes your health and our Practice.

Dismissal. Failure to comply with the practice financial policies may result in you and your immediate family members being discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

filed for all services rendered and a separate statement will be sent from each entity. Please pay each statement separately.

Non-payment - If any balance is over 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full in order to avoid being turned over to an outside collection agency. Partial payments will not be accepted unless a payment plan has been established and followed as scheduled. If at any point, a payment is missed, the collection process will pick up where it left off and the account could be referred immediately to an outside agency.

Collection Agency - If the account is referred for collection, agency fees up to 33% of the original balance will be added to the account to cover these external expenses which are unrelated to your balance with DHS. An additional fee of $150 (minimum) for attorney fees, plus all pre-judgment cost of collections to include court cost in the jurisdiction of the Lee County, Mississippi court system for enforcement of payment of this account will be added in the event the account is forced into litigation.

Credit Balances – In the event that a credit balance is created on any account (professional or facility), we will verify there are no outstanding balances on either the DHS or CDH account before initiating a refund. Because of the administrative expense of processing a refund, any credit balance of $10.00 or less will remain on the account for use at a future visit unless the refund is specifically requested.

Contact Consent – I give direct consent to receive communications regarding my accounts, appointments and treatment from this office or any servicers or collectors of my accounts, through various means such as: any cell, landline or text number that I provide, any email address that I provide, auto dialer system, voicemail messages and other forms of communications.

Please acknowledge your acceptance by providing contact information and signing where indicated below:

I prefer to be contacted by:
__ Cell Phone Number _____
__ Home Phone Number _____ (texting unavailable)

Digestive Health Specialists, PA uses an electronic medical record (EMR) system to improve patient care. The web portal that is provided and maintained by North MS Medical Center makes portions of your medical record available to patients and caregivers. All communications are carried over an industry standard secure, encrypted connection. To initiate the Patient Portal and receive your personal identification number (PIN), please provide your email address below and respond to the notification you will receive within 30 days. You may also sign up for this free service by accessing registration at www.nmhs.net/portals.php. For additional information about the benefits of registering for the NMHS Patient Portal, please ask the receptionist.

Email address: _____

Our practice is committed to providing the best treatment to our patients. In return, your adherence to these office and financial policies is requested and expected. Please let us know if you have any questions or concerns.

I have read and understand the Digestive Health Specialists, PA office and financial policies dated April 1, 2018 and agree to comply with these terms as outlined above. A copy of this document shall be valid as the original.

Patient Name: _____ **Signature:** _____
Patient or Responsible Party

Date: _____ **Witness:** _____

(For Office Use Only) Medical Record #: _____

Patient Name: _____ **DOB:** _____ **SS#:** _____

I, the undersigned, agree to the following:

GENERAL CONSENT FORM

Consent for Medical Treatment

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I also understand that I will be billed for those services provided. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of treatment or examination in this clinic. I understand that my medical record may be maintained by a computer-based system and authorize access to persons involved in my care. (_____)

Assignment of Benefits

I hereby assign to DHS or its duly authorized agents and/or assigns, all rights, benefits and interests in all proceeds from all Third Party Payers. I further authorize DHS to take all necessary actions to ensure that any insurance benefits otherwise payable to me or my estate are paid directly to DHS. This authorization includes, but is not limited to, billing insurance, filing petitions, filing suit in name or on behalf of the Clinic, filing proof of claims, filing probate claims and filing grievances and all other similar procedures. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. (_____)

Authorization and Release and Use of Medical Information

I authorize DHS and DHS' designees to disclose to payers, including but not limited to insurers, workers compensation carriers, the Center for Medicare and Medicaid service, or to any other parties may be liable for all or part of the DHS charges. ("Third Party Payers"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payers to pay directly to DHS. I also authorize DHS to utilize by medical information, or to release all or part of my medical information to other health care providers consulted by my physician or DHS, as may be necessary. I understand that DHS will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or DHS operations. I have been offered an opportunity to review in detail how this medical information can be used and disclosed and how I can access that information. I understand that DHS reserves the right to change the terms of its Notice provisions and that I can obtain from the Clinic any revisions to the Privacy Policy. I also understand that I have the right to request that the Clinic restrict the release of medical information; however, DHS is not required to agree to these restrictions. (_____)

PATIENT CARE DIRECTIVE

This is to authorize physicians, nurse or other employees of Digestive Health Specialists, P.A. to speak with or release information to (my spouse, children, siblings, next of kin or caregiver) whose name(s) are listed below:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Patient Signature: _____ **Date:** _____