Digestive Healthcare Specialists. LLC
Tanya Davis, M.D./ Ashita Shah, P.A.-C

Patient' Name: _____ **Social Security** _____
Last First Middle

Date of Birth_____**Age:**_____ **Marital Status: M S W D** **Sex: M/F** **Email:** _____

Language Spoken_____ **Hispanic Yes or No** **Race**_____ **Height** _____ **Weight**_____

Address _____
Street City State Zip

Home Phone #_____**Work Phone #**_____**Cell Phone #**_____

Occupation_____**Employer's Name**_____

Employers Address:_____
Street City State Zip

Referred by or Primary Care Physician: _____**Physician's Office #**_____
Physician's Fax #_____

Emergency Contact (Someone that does not live with you): _____
Name Relationship Home Phone Number

Pharmacy Address: _____**Pharmacy Phone(**_____**)**_____-_____

Pharmacy Fax (_____**)**_____-_____

PERSON FINANCIALLY RESPONSIBLE (if different from above)

Name :_____**Date of Birth**:_____ **Social Security #**:_____**Home Phone#**_____

Relationship to Insured: Self ___Child___Spouse___Other_____ Occupation_____Work Phone #_____

Address_____
Street City State Zip

PRIMARY INSURANCE

Insurance Company Name:_____**Policy #**_____**Group #**_____

INSURED (If different than patient)

Policy in name of (insured) _____**Birth Date**_____ **Social Security #**_____

Home phone #_____**Work phone #**_____**Cell phone #**_____

Address_____
Street City State Zip

SECONDARY INSURANCE

Insurance Company Name: _____**Policy #**_____**Group #**_____

INSURED (If different than patient)

Policy in name of (insured) _____**Birth Date** _____**Social Security** _____

Home phone #_____**Work phone #**_____**Cell phone #**_____

Address_____
Street City State Zip

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Digestive Healthcare Specialists, LLC to release medical information that may be necessary to request claim reimbursement from my insurance company to whom claims have submitted. I certify that the information I have reported regarding my insurance coverage is correct. I also assign the claim payments to be made payable to Digestive Healthcare Specialists, LLC directly and I understand that any overpayment will be refunded to me from the doctor's office.

I understand that I will be responsible for any unpaid balance after my insurance company has paid and for services provided when I fail to designate a primary care physician with my insurance plan. After services are rendered, I should call my insurance company to verify receipt of claim.

I understand that if my insurance company does not pay within 60 days I will be responsible. I understand that there is a $25.00 fee for a returned check. I understand that if any unpaid balance necessitates legal action (attorney/court fees/collection agency fees) to collect this balance, I will be responsible for all attorney, court costs, and collection agency fees. **There is a $50 fee for cancelled office appointments with less than 48 hours notice and $150 fee for cancelled procedures with less than 72 hour notice.**

_____

Patient History Form

Last Name	First Name	MI	Date of Birth

Primary Care Physician	Other doctors involved with your care:

REVIEW OF SYSTEMS

Have you or the patient ever had any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? O Yes O No

SYSTEM	No	Yes	SYSTEM	No	Yes	SYSTEM	No	Yes	SYSTEM	No	Yes
Gastrointestinal			**Cardiac**			**Neurologic**			**Ear, Nose & Throat**		
Diarrhea			High blood pressure			Seizures			Loose Teeth		
Constipation			Low blood pressure			Weakness			Nosebleeds		
Rectal Bleeding			Irregular heartbeat			Migraines			Deafness		
Change in BM's			Heart Attack			Previous stroke			**Psychosocial**		
Weight loss			**Respiratory**			**Musculoskeletal**			Alcoholism		
Polyps			Asthma			Muscle Disease			Substance Abuse		
Irritable Bowel			Pneumonia			Arthritis			Depression		
Crohn's Disease			Bronchitis			Neck Pain			Anxiety disorders		
Ulcerative Colitis			Chronic Cough			Back pain			**Breast Lumps**		
Difficulty Swallowing			Hoarseness			Blood Disorders			**Cancer**		
Nausea/Vomiting						**Skin**			Please list below:		
Heartburn			**Genitourinary**			Rash			Any symptoms/disease		
Abdominal Pain			Kidney Disease			Bruises			not listed above?		
Hepatic			Frequent urine infection			**Ophthalmic**					
Liver Disease			**Endocrine/Metabolic**			Cataracts					
Hepatitis			Diabetes			Glaucoma					
Pancreatitis			Thyroid Disorders			Blindness					

PAST HISTORY

Please explain and YES answers in detailed description in the box provided.

Have you had any problems with anesthesia? **No** _____ **Yes** _____ If yes, please list below:	**Surgeries**	**Dates**:	**Hospitalizations other than surgery**	**Dates:**
Do you have any ALLERGIES (including environmental, medication, food, and reaction to previous blood transfusions)? **No** _____ **Yes** _____ **If yes, Please list →**	**ALLERGIES**	**TOBACCO**: How many packs per day? _____ How many years? _____	**DRUGS**: Are you or have you ever used recreational/illicit drugs? If yes, please list _____	**ALCOHOL**: How many drinks per day _____ Per week _____ per month _____

MEDICATIONS:

Are you currently taking any medications or drugs (including over-the-counter, prescriptions, birth control pills)? **No** _____ **Yes** _____ **Please list →**	**Medication**	**Dose**	**Times**	**Medication**	**Dose**	**Times**

FAMILY HISTORY: Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	Relation to Patient	Condition	Relation to Patient	Condition	Relation to Patient
Colon/rectal Cancer No Yes		Kidney Problems No Yes		Heart Disease No Yes	
Stomach Cancer No Yes		Ulcerative Colitis No Yes		Crohn's Disease No Yes	
Breast Cancer No Yes		Ovarian Cancer No Yes		Bleeding Problems No Yes	

_____ Person Completing this form/relationship to patient

_____ Reviewed by Provider Date(s)

Digestive Healthcare Specialists, LLC

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. **Please review it carefully.** At Digestive Healthcare Specialists, LLC., we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care. We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information. You have the right to receive a report of who we disclose your information to. If our privacy and security measures or systems are breached in any way, we will notify you. You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Nurse Manager Ekaterina Lawhead at (703)780-7010 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy

Effective September 23, 2013

Digestive Healthcare Specialists, LLC

2616 Sherwood Hall Lane
Suite 307
Alexandria, VA 22306

6355 Walker Lane
Suite 300
Alexandria, VA 22310

CONSENT AGREEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health care providers provide a Privacy Notice and, optionally, may require a Consent Agreement as it relates to the use and disclosure of individually identifiable health information (IIHI). This allows Individually Identifiable Health Information to be used or disclosed for treatment, payment and other health care operations (TPO) purposes only, unless authorization is specifically denied by the patient.

Though not necessary to have your consent to allow us to use or disclose your IIHI to others who will treat you or support in providing you quality health care services, it is important to have you consent to use or disclosure you IIHI to health care plans to insure accurate and timely payments for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI and to provide you our Privacy Notice. We may already have a consent agreement from you, but under the new Privacy Standard, we are required to provide you our Privacy Notice that specifically addresses the use or disclosure your IIHI. Please refer to our Privacy Notice for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I _____ have been presented with a Privacy Notice explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

PATIENT: _____ DATE: _____

Effective September 23, 2013