Name: _____ **Prescheduled Procedure:**
Date of Birth: _____ **Date:**
Today's Date: _____ **Check-in:**

☐ **New patient** ☐ **Established patient**

COLON & DIGESTIVE
HEALTH SPECIALISTS

HISTORY COMPLETED BY PATIENT

Reason for your visit today: _____

Are you experiencing any current problems, signs or symptoms in any of the following areas:

- ☐ General Wellness
- ☐ Reproductive/Urinary
- ☐ Allergies
- ☐ Ears, Nose, Throat
- ☐ Thyroid/Endocrine
- ☐ Stomach/Digestion
- ☐ Heart/Circulation
- ☐ Swelling & pain in muscles/joints/bones
- ☐ Neurological
- ☐ Eyes
- ☐ Skin rash
- ☐ Psychiatric
- ☐ Blood/Lymph
- ☐ Lungs/Breathing
- ☐ Other_____

Current medication(s), (drugs, pills):

☐ Plavix ☐ Coumadin ☐ Pradaxa

☐ Aspirin/Baby Aspirin ☐ Pletal

☐ Any other blood thinners: _____

Other Medications:

_____

_____

_____

_____

LIST ANY ALLERGIES:

_____

LIST ANY ALLERGIES TO MEDICATIONS:

_____

Do you have:

- ☐ Abdominal pain
- ☐ Gas & bloating
- ☐ Nausea & vomiting
- ☐ Rectal bleeding
- ☐ Jaundice or hepatitis
- ☐ Lactose intolerance
- ☐ Difficulty swallowing
- ☐ Reflux or heartburn
- ☐ Acid indigestion
- ☐ Weight loss
- ☐ Chest Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Dark Stools
- ☐ Hemorrhoids

Previous Medical problems or surgeries:

- ☐ Artificial Heart valve
- ☐ Prosthetic joints
- ☐ Recent Heart Attack
- ☐ Mitral valve prolapse
- ☐ COPD/emphysema
- ☐ Bleeding disorder
- ☐ Gallbladder surgery
- ☐ Cancer of _____
- ☐ Ulcers
- ☐ Diabetes
- ☐ Anemia
- ☐ Colon polyps
- ☐ Colon cancer
- ☐ Kidney failure
- ☐ Blood transfusion
- ☐ Other _____

☐ **DATE OF YOUR LAST COLONOSCOPY**:

_____

What is your social history:

Do you smoke? _____ How many packs a day? _____ For how many years? _____When did you quit smoking? _____
Do you drink alcohol? _____ How many drinks per week? _____ When did you quit drinking? _____
Have you ever used recreational drugs? _____ If yes, when? _____ and what kind? _____
Tattoos ☐ Yes ☐ No

Family history of medical problems:

Mother:_____
Father: _____
Siblings: _____
Children: _____

Family history of colon polyps? ☐ Yes ☐ No **Family history of colon cancer?** ☐ Yes ☐ No
Family history of other cancer? ☐ Yes ☐ No Site:

For Office Use Only:

BP:
Pulse:
Weight:

I have reviewed the history as documented above and personally noted the chief complaint.

Doctor's Signature: _____ Date: _____

COLON & DIGESTIVE HEALTH SPECIALISTS

PHYSICIAN: Dr. Nizar Ramzan MD, AGAF ☐ Dr. Jaffrey Kazi MD ☐ Kelly Kollman PA-C ☐

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Age:** _____ **Sex:** Male ☐ Female ☐ **Marital Status:** _____

Address: _____ **APT #:** _____/ **City:** _____/**State:** ____/**Zip:** _____

Home Phone: _____ **Cell:** _____ **Work Phone:** _____

Social Security#: _____ *(If you chose not to write down your social, please create a 9 digit number that you will remember. We use this for Med Voice to deliver your test results)*

Email Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Federal Privacy Standards require the following information:

Ethnicity: _____ (i.e. Caucasian/Hispanic/Asian) **Race:** _____ (i.e. American/Mexican/German) **Preferred Language:** _____

Employment Status: FT ☐ PT ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Student ☐ Active Duty ☐

Employer/School: _____ **OCUPATION:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Primary Insurance Company: _____ **Person Insured:** _____

Insured Social Security Number: _____ **Insured Date of Birth:** _____

Secondary Insurance: _____ **Person Insured:** _____

Read the following information carefully and sign below:

Medical care is based upon mutual understanding and confidence. You may discuss with the physician any questions regarding fees. Our billing service will assist in filing your insurance. **You, the patient, are responsible for your medical bill.** It is your responsibility to contact your insurance company prior to your office visit or procedure(s) to ensure your coverage benefits. CDHS will pre-certify your procedures. This pre-certification does not guarantee coverage or benefits.

RELEASE OF INFORMATION REGARDING TEST/PROCEDURE RESULTS:

Who may receive information regarding your Protected Health Information?

Spouse – Name and DOB: _____

Children – Names and DOB: _____

Significant Other/Friend – Name and DOB: _____

May we leave messages regarding test results on your voice mail? YES ☐ NO ☐

Patient Signature: _____ Date: _____

Please list *all* other physicians participating in your care & the pharmacy you use *frequently*:

PRIMARY CARE DOCTOR: _____ Telephone Number: _____

REFERRING PHYSICIAN: _____ Telephone Number: _____

PHARMACY: _____ Telephone Number: _____

ALL OTHER PHYSICANS: _____

_____

Colon & Digestive Health Specialists Financial Policy
Effective June 1, 2009

Thank you for choosing Colon & Digestive Health Specialists as your gastroenterology specialist. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that Colon & Digestive Health Specialists will collect, prior to any office visit and procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and Colon & Digestive Health Specialists. Our office will provide written notification to you detailing anticipated charges. If full deductible is not applied to your claim by your insurance company, we will refund any overpayment to you within 30 days of the date we receive the overpayment.

3. _____ I understand that if my account is not paid in full within 90 days, a $35 collection processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

4. _____ I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

5. _____ I understand that if I am unable to make a scheduled appointment I need to contact Colon & Digestive Health Specialists at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent endoscopic care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

6. _____ Colon & Digestive Health Specialists will allow 60 days from the date of filing for my insurance company to process or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. **It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Colon & Digestive Health Specialists if there is any change in my insurance coverage, residence, or phone number.**
ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

7. _____ ***I have read and I understand the above Financial Policy and I agree to abide to its terms.***

_____ _____
Printed name of patient Signature of Patient/Responsible Person

_____
Date

COLON & DIGESTIVE
HEALTH SPECIALISTS

NOTICE OF PRIVACY PRACTICES

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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes symptoms, test results, diagnosis, treatment, and related medical information. Your health information
Also includes payment, billing, and insurance information.

How We Use Your Patient Health Information.
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filing your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to access the care and outcomes of your case and others like it.

Special uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries or events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we May disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibilities for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required to military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you may later revoke that authorization to stop any future uses or disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses or disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You must ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe the information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances when we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post a new Notice in the waiting room and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Privacy Officer
8761 E Bell Road #105
Scottsdale, AZ 85260
(480) 219-6662

SIGN BELOW

Effective date: April 14, 2011

I, _____
Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was

not obtained: _____

Staff Witness seeking acknowledgement:

Signed: _____

Date: _____