DEEP CREEK COLON AND RECTAL SURGERY, PC
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Patient Information

Today's Date:_____ Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Widow(er)

Patient's Last Name:_____First:_____Middle:_____

Birth Date:_____Age:_____Sex: Male_____Female_____ Best Contact #:_____
Circle: Home / Work / Cell

Street Address:_____Last 4 Digits of SS#_____ Alternate Contact #:_____
Circle: Home / Work / Cell

City:_____State:_____Zip Code:_____ Email Address:_____
(For non-medical communication only)

Race: ◯ American Indian/Alaskan Native; ◯ Asian; ◯ Black/African American; ◯ White; ◯ National Hawaiian/Pacific Islander; ◯ Other

Ethnicity: ◯ Non-Hispanic/Non-Latino; ◯ Hispanic/Latino

Name of Referring Doctor: _____Primary Care Doctor:_____

Pharmacy Name:_____Pharmacy Address (Street/City):_____

Insurance Information

Primary Insurance Company:_____
Subscriber ID/Member Number:_____Group Number:_____

Patients Relationship to Subscriber: ◯ Self (If self, skip to secondary if applicable); ◯ Spouse; ◯ Child; ◯ Other

Subscriber's Name:_____Subscriber's Birth Date:_____

Subscriber's Address:_____If Tricare – Sponsor's SS#:_____

Secondary Insurance Company:_____
Subscriber ID/Member Number:_____Group Number:_____

Patients Relationship to Subscriber: ◯ Self (If self, skip to next section); ◯ Spouse; ◯ Child; ◯ Other

Subscriber's Name:_____Subscriber's Birth Date:_____

Subscriber's Address:_____If Tricare – Sponsor's SS#:_____

In Case of Emergency

Name of local friend or relative:_____Relationship to Patient:_____

Primary Phone:_____Secondary Phone:_____Is this individual authorized to discuss you medical information? ◯ Yes ◯ No

List any other individuals authorized to discuss your medical information:_____

To the best of my knowledge, the above information is true. I have read a copy of the following office policies and procedures: **Notice of Privacy Practices** (HIPAA), **Office Visit Policies** (including Financial Responsibilities), **Patient Bill of Rights &. Responsibilities** (including advanced directives), and **Electronic Communication Policy** (permitting the use of email for non-medical communication). By my signature below, I agree to adhere to all such policies. I may make changes to my email election and/or individuals authorized to discuss my medical information at any time in writing. In addition, copies of these policies and procedures have been offered to me, and are available in the office, I may request a written copy at any time.

Patient/Guardian Signature:_____Date:_____

Patient Acknowledgement/Consent Form/Authorization
Use and Disclosure of Protected Health Information

DCCRS "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. This document is available in our waiting room and upon request. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing below:

_____
Patient's Initials

DCCRS "Notice of Privacy Practices" states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy upon your next visit to our office._____

Patient's Initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We will discuss this request with you if there is a concern that the decision may not be in your best interest. We are bound by our agreement with you.

_____
Patient's Initials

DCCRS, or its designated representative, may leave messages on my (the patients) answering machine regarding appointments and payment information or arrangements, and prescription information. Confidential information such as, but not limited to lab results and pathology results will not be left. By not signing you do not agree with this policy and no information will be left on answering machines.

_____
Patient's Initials

DCCRS has my permission to review my medical and prescription records, both internal and external, to assist them in my medical care.

_____
Patient's Initials

DCCRS has permission to take my digital picture so that it may be inserted into my Electronic Medical Record file to help with ID.

_____
Patient's Initials

OFFICE PROCEDURES: It is common for a diagnostic procedure, including an anoscopy or proctoscopy, to be performed as part of your exam to assist us in diagnosing an anorectal medical condition. Your insurance carrier may define them as a "surgery" or "surgical procedure" and you may incur additional charges reflecting their classification of these terms. Additionally, if any biopsy or treatment is performed, there will be an additional charge. In both of these instances you may have additional copayment, co-insurance or deductible fees. We do not control how the insurance company classifies treatment.

_____
Patient's Initials

Our offices participate with CRISP, Chesapeake Regional Information System for our patients. This is a regional health information exchange serving Maryland and D.C. Please ask for a form to complete if you do not want to participate. We have patient education material in the waiting room if you would like to learn more about CRISP.

By signing this form, you consent to treatment of the person named on this form and our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already rendered treatment and/or made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Deep Creek Colon and Rectal Surgery, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Please contact our office at least 2 working days prior to canceling any scheduled procedure. A $125.00 cancellation fee may be charged to the patient if this notice is not given. Insurance companies will not pay for this fee; it will be the patient's responsibility.

As a courtesy to our patients we will submit your claim to your insurance carrier at no extra charge. Patients not making payments or payment arrangements within 3 months of the date of service will have their accounts sent to a collection agency and be subject to the fees charged by the collection agency.

I attest that the information provided is true and correct as of the date below. I have read and understood the above conditions: I have also been given the opportunity to ask questions, by giving my signature I agree to the terms of this agreement. This signature will be valid for one year from the date of signature unless revoked in writing.

Date:_____ Signature:_____