



# Digestive Care Physicians, LLC

Ph: 770-227-2222 • Fx: 770-227-2220 • www.digestivecarephysicians.com

Ranvir Singh, MD  
Stephen Rashbaum, MD  
Priya Ravindran, MD

## CONFIDENTIAL PATIENT INFORMATION SHEET (Please Print)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Sex: \_\_\_\_\_  
(Last) (First) (Mi)

Street Address: \_\_\_\_\_ Apt: \_\_\_\_\_ SS#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**Race:**  American Indian / Alaska Native  Native Hawaiian **Ethnicity:**  Hispanic / Latino  
 (Required  Asian  Other Pacific Islander  Other:  
 by  Black / African American  Undefined  Refused to Report  
 Medicare)  More than 1 Race  White  Refused to Report  Undefined

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph/Cell: \_\_\_\_\_

Nearest Relative (not living with patient) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Spouses' Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

### Employment Information

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Insurance Information

(Please present all insurance cards and picture I.D. to front desk for photocopying)

Primary Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's D.O.B: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's D.O.B: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### MEDICAL CONSENT - ASSIGNMENT OF BENEFITS - RELEASE OF INFORMATION

I hereby authorize the physician and staff of **Digestive Care Physicians, LLC** to provide medical care for the above named patient.

I hereby authorize **Digestive Care Physicians, LLC** to release any information in my examination or treatment to any insurance, government agency providing benefits or other policies to process any claims on my behalf for payment.

I hereby with my signature assign and authorize my insurance carrier(s) to make payment directly to **Digestive Care Physicians, LLC** for all services rendered. I hereby with my signature understand I will be charged an additional fee of forty-five dollars (\$45.00) for any check or draft dishonored by any financial institution. In the event of collection placement of my account, I understand that I will be charged a placement fee of forty-five dollars (\$45.00) in addition to the balance subject to collection.

I hereby with my signature, understand that I am ultimately responsible for payment in full of all services rendered, in the event my insurance carrier and or managed care plan denies payment in full or part of any services rendered; including but not limited to all co-payments and or deductibles, and non covered services and supplies obtained during the course of care.

I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

X \_\_\_\_\_

Signature of Patient

Date: \_\_\_\_\_



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11459 Johns Creek Pkwy., Suite 240 • Johns Creek, GA 30097

3400-A Old Milton Pkwy., Suite 545, Alpharetta, GA 30005

## PATIENT COMMUNICATION CONSENT FORM

In compliance with federal law, it is the policy of Digestive Care Physicians, LLC to **NOT** release confidential, personal, and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cellular telephone, pager and/or fax. We will not leave a message on an answering machine where the recorded message does not identify the name or number called. Information will not be left with an unauthorized person who may answer your telephone.

I authorize Digestive Care Physicians, LLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify Digestive Care Physicians, LLC whenever this information changes.

### Please list authorized numbers:

Home Telephone: \_\_\_\_\_

Answering Machine: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

Voice Mail: \_\_\_\_\_

Cellular Telephone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

I authorize Digestive Care Physicians, LLC to leave medical information pertaining to my care to the following person/persons and will assume responsibility to notify Digestive Care Physicians, LLC whenever this information changes.

### Please list authorized names and numbers:

Spouse/Significant Other: \_\_\_\_\_

Parent: \_\_\_\_\_

Brother/Sister: \_\_\_\_\_

Son/Daughter: \_\_\_\_\_

Friend: \_\_\_\_\_

## PRIVACY PRACTICE ACKNOWLEDGMENT

I have received a copy of the Digestive Care Physicians, LLC, Notice of Privacy Practices.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature / Social Security Number

X \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian Signature (if patient is under 18)

Ranvir Singh, MD



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### **PATIENT AGREEMENT**

#### **Payment For Service**

Payment is required at the time of service. We accept cash, check, Visa, MasterCard, Discover and Amex, or your banking check card. If you must pay more than your co-pay for your scheduled surgical procedure, payment is expected at the time of service. We are unable to bill you for your office visit co-pay and are unable to process our claim for your visit without having collected your co-pay. **Therefore, all co-payments will be collected at Check-In.**

#### **Courtesy Filing Of Claims**

As a courtesy, we will file your insurance. Filing your insurance is not a means of payment and does not preclude you from paying your co-payment or your co insurance today. Should your insurance company deem all or part of our charges for your care today, "non-payable", you will be responsible for payment on those charges. **To avoid misunderstandings, our billing department is available to answer questions regarding fees or payments prior to your visit from 8:30 a.m.- 5:00 p.m. 770-227-2222.**

#### **Negotiating of Claims**

We do not accept responsibility for negotiating claims with your insurance company or any other persons. We will however, do whatever possible to assist in payment. If a claim remains outstanding for 60+ days the balance will be transferred to patient responsibility. You are responsible for payment of your medical care within a reasonable time regardless of the status of claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

#### **Scheduling Fee's**

In the event that you are unable to keep your scheduled surgical appointment we simply ask that you contact our office 24 Hours **PRIOR** to your scheduled appointment date and time. **Should you "No-Show" for a scheduled Colonoscopy or Upper Endoscopy procedure you will be required to provide us with your credit card number to hold your next Surgical Appointment - should you "No-Show" for the second scheduled slot your card will be charged a \$150.00 No-Show fee.**

**As our surgical schedule is maximized to best coordinate your care, we discourage the need to reschedule your Procedure repetitively therefore, we may require a \$50.00 rescheduling fee in the event that you need to move your appointment based on non-medical reasons.**

#### **\*Unpaid Account Balances:**

All accounts that remain unpaid past the receipt of the third patient statement will accrue a \$25.00 transfer fee on top of the past due balance and then be transferred to our outside collections agency.

#### **Referrals:**

**Please take note that if you hold an HMO Insurance Policy or Medicaid that it is your responsibility to obtain and maintain a written referral from your referring physician for services rendered in our office. Failure to obtain referrals will result in your co-payment, deductible and coinsurance balances being higher. If you have questions regarding this statement please contact our Office Manager at 770-227-2222.**

#### **Disclaimer:**

Insurance companies will not guarantee payment when we call for authorization. **Therefore, it is imperative that you call your insurance company to verify your benefits.** Our medical assistant does as a courtesy, verify benefits, but there can be misquotes and or misunderstandings - you will be responsible for all fees deemed "patient responsibility" when we receive your Explanation of Benefits.

\_\_\_\_\_  
Patient Signature (Guardian)

\_\_\_\_\_  
Date



### Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your Individually Identifiable Health Information. Please review this carefully.**

**A. Our Commitment to your Privacy.** Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

**The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

**B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

DIGESTIVE CARE PHYSICIANS, LLC. TELEPHONE: 770-227-2222.

**C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS**

The following categories describe the different ways in which we may use and disclose your IIHI:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses-may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our Practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

**OPTIONAL:**

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

**OPTIONAL:**

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

**OPTIONAL:**

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

**OPTIONAL:**

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment for a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

**D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES.** The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
  - Maintaining vital records, such as births and deaths
  - Reporting child abuse or neglect
  - Preventing or controlling disease, injury or disability
  - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
  - Reporting reactions to drugs or problems with products or devices
  - Notifying individuals if a product or device they may be using has been recalled.
  - Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
  - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
  - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
  - Concerning a death we believe has resulted from criminal conduct
  - Regarding criminal conduct at our offices

(continued on other side)

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victims(s) of the crime, or the description, identity or location of the perpetrator).

**OPTIONAL:**

5. **Deceased Patients.** Our practice may release IHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**OPTIONAL:**

6. **Organ and Tissue Donation.** Our practice may release your IHI to organization that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**OPTIONAL:**

7. **Research.** Our practice may use and disclose your IHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IHI is being used only for the research and (iii) the researcher will not remove any of your IHI from our practice; or (c) the IHI sought by the researcher only related to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access of the IHI of the decedents.

8. **Serious Threats to Health or safety.** Our practice may use and disclose your IHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your IHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** Our practice may disclose your IHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your IHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your IHI for workers' compensation and similar programs.

**E. YOUR RIGHTS REGARDING YOUR IHI.** You have the following rights regarding the IHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Digestive Care Physicians, LLC, 1505 Northside Blvd., Ste. 2850, Cumming, GA 30041** and specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IHI, you must make your request in writing to: **Digestive Care Physicians, LLC, 1505 Northside Blvd., Ste. 2850, Cumming, GA 30041.** Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: **Digestive Care Physicians, LLC, 1505 Northside Blvd., Ste. 2850, GA 30041** in order to inspect and/or obtain a copy of your IHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: **Digestive Care Physicians, LLC, 1505 Northside Blvd., Ste. 2850, Cumming, GA 30041.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IHI kept by or for the practice; (c) not part of the IHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IHI for non-treatment or operations purposes. Use of your IHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to: **Digestive Care Physicians, LLC, 1505 Northside Blvd., Ste. 2850, Cumming, GA 30041.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact **Digestive Care Physicians, LLC, 1505 Northside Blvd., Ste. 2850, Cumming, GA 30041**

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Digestive Care Physicians, LLC, 1505 Northside Blvd., Ste. 2850, Cumming, GA 30041.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact: **Digestive Care Physicians, LLC, 1505 Northside Blvd., Ste. 2850, Cumming, GA 30041** or Call at **770-227-2222.**

I acknowledge that I have received the Notice of Privacy Practices.

Signature

Date