CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Dear Patient:

Welcome and thank you for choosing Capital Digestive Care!

The enclosed packet contains important information for your upcoming appointment as well as our new patient registration forms. To be prepared for your appointment, please review this information carefully and bring the requested information with you on the day of your appointment.

It is very important to bring the following to every visit:

√ Completed Patient Information Forms, Patient History Forms & Signed Notice of Privacy Practices (enclosed in this packet)

√ Insurance Card(s) and Insurance Referral, if applicable

√ Picture Identification (such as a driver's license)

√ Any recent Laboratory (blood work) results related to your visit with us

√ Any recent Radiology results related to your visit with us (e.g., Upper GI Testing, Barium Enema, CT scan or Ultrasound results)

√ A list of your current medications with dosage and frequency taken

√ For patients enrolled in HMO plans, a referral may be required from your Primary Care Physician. Please check with your insurance carrier to verify the requirements of your plan

√ Co-payment, if applicable. Please note that payment is due at the time of service.

If you have been referred due to an abnormal laboratory/radiology result, it is imperative that we have a copy of these results so that we can complete your consultation without having to repeat testing.

Providing the above information on the day of your appointment will allow us to serve you in the most prompt, accurate and efficient manner.

Thank you for allowing us to participate in your medical care.

We look forward to seeing you soon.

* Capital Digestive Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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Patient Information

Patient Last Name:	Patient First Name:	Patient MI:
Preferred Name:	Gender:	Date of Birth:
Race Type: ☐ White ☐ Black or African American ☐ Asian American ☐ Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other		
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declines to Specifiy		
Patient Address:		City:
State, Zip Code:	Home Phone:	Cell Phone:
Email address:		
Emergency Contact:	Emergency Contact Phone:	Circle: Home / Cell / Work
Primary Care Physician:	Legal Representative if Patient is a Minor or for other reasons necessary:	
Referring Physician:		Patient Preferred Language:

Primary Insurance Coverage:

Carrier:	Policy ID #:
Carrier Phone:	Group ID / Name:
Claims Address:	Plan ID / Name:
City, State, Zip code:	Subscriber DOB:
Subscriber Name:	Patient Relationship to Subscriber:
Subscriber Gender: M □ F □	Subscriber Employer:

Secondary Insurance Coverage:

Carrier:	Policy ID #:
Carrier Phone:	Group ID / Name:
Claims Address:	Plan ID / Name:
City, State, Zip code:	Subscriber DOB:
Subscriber Name:	Patient Relationship to Subscriber:
Subscriber Gender: M □ F □	Subscriber Employer:

I understand that I am financially responsible for any balance not covered by my insurance. I will pay those balances due within 20 days of receipt of a statement. If my account becomes delinquent, Capital Digestive Care may employ the services of a collection agency to recover any outstanding balance on the account. If the account is sent to an external agency, I agree to pay all costs of collections, including collection agency fees in the range of 16% plus any interest allowable by law, if incurred.

I am aware that a fee of $50.00 will be charged for any modification to an office visit within 2 business days of the appointment. A fee of $150.00 will be charged for any modification to a procedure appointment within 5 business days of the appointment. The credit card on file will be charged within 10 business days.

Signature of Patient or Representative: _____ Date: _____

Revised

CAPITAL DIGESTIVE CARE℠
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BILLING CATEGORY ASSIGNMENT OF BENEFITS FORM

During the course of your evaluation and treatment, physicians and professionals outside of Capital Digestive Care may be involved in your care. Following a procedure, such as endoscopy or colonoscopy, it is common to be billed for physician services, anesthesia services, pathology services (if a biopsy was taken) and facility fees. **Each entity will bill separately for services provided.** You are free to utilize any health care facility or provider of your choice, subject to the restrictions of your physician's affiliation or restrictions which may exist under your health insurance coverage. Patients should check with their health insurance provider if they have any questions or concerns about their coverage.

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Capital Digestive Care affiliated organizations:

Maryland, DC, and Virginia Physician Billing	**Maryland and DC Facility Billing** *(one of the following)*	**Maryland and DC Anesthesia Billing** *(one of the following)*	**Maryland, DC, and Virginia Pathology Billing**
CAPITAL DIGESTIVE CARE, LLC	AMBULATORY ENDOSCOPY CENTER OF MARYLAND	CORRIDOR ANESTHESIA, LLC	CAPITAL DIGESTIVE CARE PATHOLOGY LABORATORY, LLC
	PE BETHESDA ENDOSCOPY CENTER ENDOSCOPY CENTER OF WASHINGTON, D.C. ENDOSCOPIC SURGICAL CENTRE OF MARYLAND ENDOSCOPIC SURGICAL CENTRE OF MARYLAND – NORTH FRIENDSHIP HEIGHTS ENDOSCOPY CENTER SOUTHERN MARYLAND ENDOSCOPY CENTER	CAPITAL ANESTHESIA PARTNERS, LLC	
	GASTROINTESTINAL ENDOSCOPY ASSOCIATES, LLC (GIEA)	CAPITAL ANESTHESIA PARTNERS, LLC	
	URBANA GI ENDOSCOPY CENTER	MARYLAND ANESTHESIA PARTNERS (MAP)	
	FALLSGROVE ENDOSCOPY CENTER	POTOMAC ANESTHESIA CONSULTANTS	

1. I understand that the companies above will disclose my personal health information (PHI) for insurance and treatment purposes only. I am allowing the release of all PHI necessary for payment and treatment of my specific health problem.
2. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance, and any other insurance plan.
3. I understand I am financially responsible for all charges not paid by said insurance company, including any deductibles, copays and co-insurance, and that copays are due at the time of services.
4. I understand my provider may order laboratory diagnostic tests to be performed by Capital Digestive Care's Laboratory. I understand that my insurance carrier may or may not provide coverage for laboratory studies and that these rules are carrier specific. By proceeding with the diagnostic testing ordered by my provider, I acknowledge I am financially responsible for all charges not paid by my insurance company, including any deductibles, copays, co-insurance, and any charges or services deemed not covered by my insurance.

_____ _____

Signature of Patient or Representative Date

_____ _____

Patient Name (Printed) Date of Birth

Revised

CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Authorization to Release Medical Information

Capital Digestive Care is dedicated to maintaining the privacy of your protected health information. Federal and state laws ensure the privacy of your medical records, their availability to you, and specific rights regarding your medical records. In addition to your authorization, we may use or disclose your health information in accordance with the law under certain circumstances. Please refer to our full HIPAA Notice of Privacy Practices for all potential general use and disclosures.

I UNDERSTAND MY RIGHTS TO:

Revoke or change the authorization below at any time. (Please note, revocation is not effective in cases where the information has already been disclosed but will be effective going forward from the notice to revoke). I may also inspect or copy my protected health information to be disclosed as described in this document. I understand that if the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

DISCLOSURE AND RELEASE OF PAPER OR ELECTRONIC RECORDS: (Choose and initial only **one** option)

_____ I **DO NOT** authorize the disclosure or release of my protected health information to any person/entity or via a
Initial message left on a voicemail beyond the authorized uses and disclosures as described in the Notice of Privacy Practices.

_____ I authorize the physicians and staff of the practice to disclose health information regarding appointments, labs
Initial bills or other general patient communication via voicemail on the following telephone numbers:

Telephone #: _____ Telephone #: _____

_____ I authorize the disclosure or release of the following protected health information:
Initial

- All records
- Office visit notes
- Pathology Reports
- Radiology Reports
- Laboratory Reports
- Other (specify): _____

This information may be disclosed or released to: Name: _____
Relationship: _____ Address: _____
_____

This authorization expires on: ____/_____/_____*(if no date specified, an automatic expiration occurs in one year)*.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name/Title of Representative

CAPITAL DIGESTIVE CARE℠
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COMMUNICATIONS NOTIFICATION

Capital Digestive Care employs a number of different resources for the purpose of contacting you to deliver important information. Your privacy is important to us and we will not share your information with any third-party except as explained in our Notice of Privacy Practices. Listed below are examples of some of the reasons we may need to reach you using the information we collect at the time of registration (for new patients) or have on file (for established patients), which may include your email address, home or mobile telephone number. Please refer to our Notice of Privacy Practices for additional information regarding the use and disclosure of your health information.

- **Patient Portal Access**: You will receive an email that contains a pin number which you will need to create your Patient Portal. When you create your portal, you will be able to update your personal information before or after your appointment, view certain test results and send messages to your doctor and/or doctor's office.
- **Practice Announcements**: These may include new physician or provider announcements or provider retirement/relocation notifications.
- **Appointment Reminders & Virtual Services**: These may include information regarding a scheduled or missed appointment via email, home phone, mobile phone or text messaging.
- **Patient Education**: You may receive video applications intended to provide necessary information regarding a scheduled procedure. You may also receive information on new treatments or clinical research trials, notification of educational seminars on specific digestive health topics or other relevant information.
- **Customer Service Improvements**: We are always evaluating applications to improve our service to you, as applications become available, you may receive a notification or registration invitation.
- **Chesapeake Regional Information System for our Patients (CRISP):** We have chosen to participate in a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.
- **Collection Activity:** If your account becomes delinquent, Capital Digestive Care may employ the services of a collection agency to recover any outstanding balance on your account. You may request the removal of your mobile number for this purpose by providing written notification to Capital Digestive Care, ATTN: Billing Manager, 10770 Columbia Pike, Suite 400, Silver Spring, MD 20901.
- **Unsecure Electronic Communications:** If you choose to communicate with us or any of your Capital Digestive Care providers via unsecure electronic communications, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication. In addition, if you provide your email address or mobile phone number to us, we may send you emails or text messages related to appointment reminders, surveys, or other general informational communications. For your convenience, these messages may be sent unencrypted. Before using or agreeing to the use of any unsecure electronic communication to communicate with us, note that there are several risks, such as interception by others, misaddressed or misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured portable electronic devices. By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that use of email or other electronic communication is not intended to be a substitute for professional medical advice, diagnosis, or treatment. Electronic communications such as email or text should never be used in a medical emergency.

Patient Name (please print): _____ **Date of Birth:** _____

Signature of Patient or Representative: _____ **Date:** _____

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CAPITAL DIGESTIVE CARE℠
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PATIENT FINANCIAL POLICY

Capital Digestive Care is committed to providing our patients with quality healthcare. Having a clear understanding of our patient financial policy is important to us. It is important to contact us with any questions if any of your personal information changes while under the care of one of our providers.

- **Insurance**: Capital Digestive Care participates with most insurance plans. Payment in full is expected at the time of service unless arrangements have been made in advance to set up a payment plan. If you are covered by insurance and have questions about your benefits, please contact the number on the back of your card.
- **Self-pay:** Capital Digestive Care provides access to patients who are not insured by offering a self-pay fee schedule. Payment in full is expected at the time of service unless arrangements have been made in advance to set up a payment plan.
- **Credit Card on File**: In an effort to improve patient services and office efficiencies, Capital Digestive Care has implemented a credit card on file policy. This will be used for any co-payments, co-insurance, deductibles, or charges that may not be covered by your health insurance. At the time of check-in, your credit card information will be obtained and kept securely as a token. Capital Digestive Care will not be able to see your credit numbers after they are saved, and a token is created. Only the last 4-digits of the card will be available for verification purposes. Once your insurance pays their portion, a statement will be mailed. Patients have 30 days to pay the balance or call our office with any questions. If your balance is not paid after 30 days, your credit card on file will be charged. The amount charged to your card will not exceed $75.00 for office visits and $150.00 for procedure visits per month.
- **Co-payments:** Capital Digestive Care expects that all co-payments are to be paid at the time of check-in.
- **Late Cancellation/ No Show Fee:** Capital Digestive Care strives to provide excellent care to each patient in a timely manner. A fee of $50.00 will be charged for any modification to an office visit within 2 days of the appointment. A fee of $150.00 will be charged for any modification to a procedure appointment within 5 days of the appointment. Your credit card on file will be charged within 10 days.
- **Collection Agency Placement Fee:** If a patient's account becomes delinquent, Capital Digestive Care may employ the services of a collection agency to recover any outstanding balance on the account. If the account is sent to an external agency, the below agrees to pay all costs of collections, including collection agency fees in the range of 16% plus any interest allowable by law, if incurred.

Patient Name (please print): _____Date of Birth: _____

Signature of Patient or Representative: _____Date: _____

CAPITAL DIGESTIVE CARE℠
First in Digestive Health

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Safeguarding Your Protected Health Information

Capital Digestive Care ("we" or "us") is committed to protecting the privacy of medical information that we create or obtain about you. That information is referred to as "Protected Health Information" or "PHI." PHI is information that identifies you and that we create or get from you or another health care provider, health plan, your employer or a health care clearinghouse and that relates to (1) your past, present or future physical or mental health or condition, (2) health care services that you received, or (3) the past, present or future payment for health care services that you received.

This Notice tells you about the ways in which we may use and disclose your PHI. It also describes your rights and certain obligations we have regarding the use and disclosure of your PHI. We are required by law to: (1) make sure your PHI is protected; (2) give you this Notice describing our legal duties and practices with respect to your PHI; and (3) follow the terms of this Notice that is currently in effect.

How We May Use and Disclose Your PHI

The following sections describe different ways that we may use and disclose your PHI. We abide by all applicable laws related to the protection of PHI. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose your PHI, however, will fall within one of the following categories:

Uses and Disclosures for Treatment, Payment and Health Care Operations

Treatment: We will use and disclose your PHI to provide you with medical treatment or services, to coordinate or manage your health care, or for medical consultations or referrals. For example, nurses, physicians and other members of your treatment team will record and use your PHI to determine the most appropriate course of care. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to authorized family members who are helping with your care.

Payment: We will use and disclose your PHI so that the treatment and services you receive at Capital Digestive Care or from others may be billed to you and payment may be collected from you, an insurance company or another third party. For example, we may need to give information to your health insurance company about a visit at Capital Digestive Care so your health insurance company will pay us or reimburse you for the visit. We may also need to obtain authorization from your health insurance company before providing certain types of treatment.

Health Care Operations: We will use and disclose your PHI our health care operations. These uses and disclosures are made to enhance the quality of care that we provide, review the competence of our health care professionals, and general business activities. For example, we may disclose your PHI to doctors, nurses, technicians and others for review and education purposes.

Other Uses and Disclosures

We may use or disclose your PHI for other reasons permitted or required by law, even without your authorization (permission), including:

Treatment Alternatives: We may use and disclose your PHI to tell you about, or recommend, possible treatment alternatives.

Our Services: We may use and disclose your PHI to inform you of health-related services, products or benefits that we may provide.

Fundraising: We may contact you to provide information about activities that we sponsor, including fundraising programs and events to support patient care at Capital Digestive Care. For this purpose, we may use your name and other limited information to contact you, including, the dates on which and the department from which you received treatment or services from us, your treating provider's name, your treatment outcome, and your health insurance status. If we do contact you for fundraising activities, the communication you receive will have instructions on how you may ask for us not to contact you again for such purposes, also known as an "opt-out."

Health Information Exchanges: We may share PHI that we obtain or create about you with other health care providers or other health care entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges ("HIEs") in which we participate. For example, information about your past medical care, current medical conditions, and medications can be available to us and your non-Capital Digestive Care physician or hospital if we participate in the same HIE. Exchange of PHI through HIEs can provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. The purpose is so that each of your participating health care providers can have the benefit of the most recent PHI available from other participating providers involved in your care. We participate in the Chesapeake Regional Information Systems for our Patients ("CRISP"), a regional health information exchange serving Maryland and D.C. As permitted by law, your PHI will be shared with CRISP in order to facilitate the secure exchange of your electronic PHI between health care providers and others for your treatment, payment, care coordination, or other health care operations purposes. Refer to our Communications Notification form if you prefer to opt out of this program.

Business Associates: We contract with third parties referred to as "business associates" to provide certain services on our behalf, such as billing and information technology. We may disclose your PHI to our business associates so they may perform the job we have asked them to do. To protect your PHI, we require our business associates to safeguard your information.

Required by Law: We may disclose your PHI when we are required to do so by federal, state or other law. For example, we may be required to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose your PHI 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 disclose your PHI to a health oversight agency for activities authorized by law, such as investigations, audits, inspections and licensure.

Judicial and Administrative Proceedings: We may disclose your PHI when ordered in a legal or administrative proceeding, such as a subpoena, discovery request, warrant, summons, court order, or other lawful process.

Law Enforcement Purposes: We may disclose your PHI to law enforcement officials for certain purposes authorized or required by law.

Deaths: We may disclose your PHI to coroners,

medical examiners, funeral directors, and organ donation agencies as necessary for them to carry out their duties.

Serious Threat to Health or Safety: We may use and disclose your PHI when necessary to prevent or lessen 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 disclose your PHI as required by military command authorities. We may also disclose your PHI to correctional institutions or for national security purposes.

Workers Compensation: We may disclose your PHI for workers' compensation or similar programs providing benefits for work-related injuries or illness.

Written Authorization: Except as described above or as permitted by law, we will disclose your PHI only with your prior written authorization. Certain uses and disclosures of your PHI for marketing purposes and any sale of your PHI require your authorization. You may revoke that authorization in writing, at any time unless we have taken action relying on your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

Individual Rights

The records of your PHI are the property of Capital Digestive Care. You have the following rights, however, with regard to the PHI that we maintain about you:

Right to Request Restrictions: You may request restrictions on certain uses and disclosure of your PHI. You have the right to restrict disclosures of your PHI to your health plan for payment and health care operations purposes (and not for treatment) if the disclosure pertains to a health care item or service for which you paid out-of-pocket in full. If requesting a restriction for a health care item or service for which you paid out-of-pocket in full, we will honor your request, unless the disclosure is necessary for your treatment or is required by law. For all other restriction requests, we are not required to agree to such restrictions.

Right to Request Confidential Communications: You may 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. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using information we have.

Right to Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your PHI in our medical and billing records and in any of our other records that are used to make decisions about you. You have the right to request that we send a copy of your medical or billing records to a third party. We request that you submit your request in writing to your caregiver or the medical records department. We may charge you a reasonable fee for providing you with a copy of your records. We may deny access under certain circumstances. You may request that we designate a licensed health care professional to review the denial. We will comply with the outcome of the review.

Right to Request an Amendment: If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the PHI. You have the right to request an amendment for as long as the PHI is kept by or for us in your medical and billing records or any other of our records that are used by us to make decisions about you. You are required to submit your request in writing to the contact person listed at the end of this Notice, with an explanation as to why the amendment is needed. If we accept your request, we will tell you we agree and we will amend your records. We cannot change what is in the record. We add the supplemental information by an addendum. With your assistance, we will notify others who have the incorrect or incomplete PHI. If we deny your request, we will give you a written explanation of why we did not make the amendment and explain your rights. We may deny your request if the PHI (i) was not created by us (unless the person or entity that created the PHI is no longer available to respond to your request); (ii) is not part of the medical and billing records kept by or for us; (iii) is not part of the PHI which you would be permitted to inspect and copy; or (iv) is determined by us to be accurate and complete.

Right to Request Accounting of Disclosures: You have the right to receive a list of certain disclosures we have made of your PHI in the six years prior to your request. This list will not include every disclosure made, including those disclosures made for treatment, payment and health care operations purposes, or those disclosures made directly to you or with your authorization. You are required to submit your request in writing to the contact person listed at the end of this Notice. You must state the time period for which you want to receive the accounting. The first accounting you request in a 12-month period will be free, and we may charge you for additional requests in that same period.

Right to be Notified in the Event of a Breach: We will notify you if your PHI has been "breached," which means that your PHI has been used or disclosed in a way that is inconsistent with law and results in it being compromised.

Right to Receive a Paper Copy of this Notice: You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Copies of this Notice will be available throughout our facilities, or by contacting the contact person listed at the end of this Notice, or you may obtain an electronic copy at our website at https://www.capitaldigestivecare.com/hipaa-notice-of-privacy-practices/.

Future Changes to this Notice

We can change the terms of this Notice, and the changes will apply to all PHI we have about you. The new Notice will be available upon request, in our office, and on our website.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about your records, you may contact the Privacy Officer at the location where you are receiving services. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

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

Capital Digestive Care
ATTN: Privacy Officer
10770 Columbia Pike, Suite 400
Silver Spring, MD 20901
PatientRelations@capitaldigestivecare.com

I _____ (Print Name) 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: _____

Date: _____

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