DIABLO DIGESTIVE CARE

400 TAYLOR BLVD. SUITE 304
PLEASANT HILL, CA 94523

OFFICE: (925) 363-0069
FAX: (925) 363-0077

WWW. DIABLODIGESTIVECARE.COM

New Patient Intake Form

Date: _____

PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Date of Birth _____ **Gender** ☐Male ☐Female **Marital Status:** _____

Address _____
Street City State Zip

Home: (____) _____-_____ **Work:** (____) _____-_____ **Cell:** (____) _____-_____

SSN: _____ **e-Mail (For Patient Portal Set-up)** _____

Occupation: _____ **Employer:** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Pharmacy Name: _____ **Phone:** _____

Pharmacy Address: _____
Street City State Zip

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

ID: _____ Group #: _____ Medical Group: _____

Subscriber Name: _____ DOB: _____ Relation: _____

Secondary Insurance: _____ Phone: _____

ID: _____ Group #: _____ Medical Group: _____

Subscriber Name: _____ DOB: _____ Relation: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relation: _____

These questions are included to comply with new Federal Health guidelines – we are required to ask for this information.

Ethnicity (check one)
☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined or Unspecified

Race (check one)
☐American Indian/Alaskan Native ☐Asian ☐Native Hawaiian/Other Pacific Island
☐Black/African American ☐White ☐Declined or Unspecified

Preferred Language (check one)
☐English ☐ Other: ☐Declined or Unspecified

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FINANCIAL AGREEMENT

Name of Patient: _____ DOB: _____

(Initial Each Line)

_____ I request that payment of all authorized Medicare/Insurance benefits be made to Diablo Digestive Care, Inc., for any medical or surgical services furnished to me by my physician or supplier.

_____ I hereby authorize the release of any and all medical information about me acquired during the course of my examination/treatment needed to make these benefits payable by the Health Care Financing Administration (Insurance Companies) and its agents.

_____ I understand that my signature requests that payment be made, and authorizes release of medical information necessary to pay the claim(s). If item 9 of the HCFA-1500 claim form is complete, my signature authorizes releasing of the information to the insurer or agency shown.

_____ I understand that my insurance company is being billed as a courtesy to me.

_____ I also understand that I am personally responsible for all charges incurred during the course of my examination/treatment, including any co-payments/co-insurance deemed my responsibility by my insurance.

_____ I am aware that any office visit co-payments set by my insurance, are due and payable to my physician or supplier at the time that services are rendered to me.

_____ I understand that any missed or no-show appointments for office visits or procedures can be billed to me.

_____ In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge; and I (the patient) am responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient: _____ Date: _____

(Please complete back side of form)

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PATIENT CONSENT & ACKNOWLEDGEMENT OF PRIVACY PRACTICES

For use and/or disclosure of Protected Health Information (PHI) to carry out treatment, payment, and healthcare operations.

(Patient) _____, hereby states that by signing this consent, agrees and acknowledges:

The Diablo Digestive Care, Inc., Privacy Notice has been offered to me to review prior to my signing this consent. The Privacy Notice includes a description of the uses and/or disclosures of my Protected Health Information (PHI) which is necessary for the facility to provide treatment to me, and also necessary for the facility to obtain payment for treatment and to carry out normal operations. I understand that the Privacy Notice will be available to me in the future upon request. The facility has further explained that it is my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent. The facility reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the facility:

1) A postcard or letter mailed to me at the address provided by me; and/or
2) Telephoning my home and leaving a message on my answering machine or with the individual who answers the phone.
3) Email to the email address I have listed in my account. Email address:_____

I understand that, and consent to, a detailed message regarding test results/treatment plan being left on a voicemail system:

____Yes Phone Number: _____
____ No A message will be left requesting you call the office.

I consent to the following persons (e.g. spouse, family member) receiving detailed information regarding my diagnosis and treatment, including test results (e.g. laboratory, x-ray, procedure, and biopsy results):

Name _____ Relationship _____ Phone _____

The facility may use and/or disclose my PHI (which includes information about my health or condition, and the treatment provided to me) in order for the facility to treat me and obtain payment for that treatment, and as necessary for the facility to conduct its specific health care operations.

I understand that I have a right to request that the facility restrict how my PHI is used and/or disclose to carry out treatment, payment and/or health care operations. However, the facility is not required to agree to any restrictions that I have requested. If the facility agrees to a requested restriction, then the restriction is binding on them.

I understand that this consent is valid for one (1) year. I further understand that I have the right to revoke this consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the facility has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.

I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice cannot treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____	_____
Name of Individual (Printed)	Signature	Date
_____	_____	_____
Name of Legal Representative/Relationship	Signature of Legal Representative	Date
_____	_____	_____
Name of Witness	Signature of Witness	Date