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Welcome to East Bay Center for Digestive Health,

EBCDH is the largest single specialty gastroenterology group practice in the East Bay and comprises seven Board certified gastroenterologists with first rate clinical training and a dedication to providing excellent diagnostic and clinical care. We also have a certified Nurse Practitioner and certified Physician Assistant who each have over 10+ years of experience in the field of Gastroenterology. We are committed to exceeding your health care expectations.

You are receiving this letter because your primary care physician has referred you to our office and you are scheduled for an endoscopic procedure.

Your colonoscopy and/or upper endoscopy will be performed at East Bay Endosurgery Center, a state of the art facility located in our building in Suite 135. Please see the instructions below for completing your REGISTRATION FORMS

- **Complete pages 2 through 6 and return to the office at least 2 weeks prior to your procedure – WITH A COPY OF YOUR IINSURANCE CARD**
  - It is important that we are able to review your medical history prior to your procedure AND be able to verify that we are contracted with your insurance and have the correct payer information on file

- **Financial Policy and Notice of Privacy Practices are for your records**

- **Please read and sign pages 7 and 8 –** You can return these with the rest of the forms or bring them with you to your appointment.

If you have not completed and returned forms prior to your procedure, you will be asked to complete them at the time of your visit. Depending on your medical status, your procedure may need to be rescheduled or even cancelled.

If you are driving, please allow time to find parking.

If you have any additional questions, do not hesitate to call your Procedure Coordinator at the extensiojn provided on your procedure instructions.

Patient Name: ________________________ Sex: M/F Date of Birth: _________ Email: __________________
Address: ____________________________ City/State/Zip: ____
Mobile Phone: ________________________ Home Phone: ___________________ Other Phone: _______________
SSN#: _______________________________ Language: __________________ Race/Ethnicity: ______________

Primary Insurance: ____________________ ID# ________________________
- Are you the subscriber for this insurance plan? Y/N If no, who is? (name/DOB) ________________________

Secondary Insurance: __________________ ID# ________________________
- Are you the subscriber for this insurance plan? Y/N If no, who is? (name/DOB) ________________________

Emergency Contact (Name & Phone #): ____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. EBCDH, Inc. will use and disclose my protected health information ("Health Information") as defined by federal and state law, in the manner described below:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnoses and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Any and all of the following Health Information may be disclosed by EBCDH, Inc. on my behalf below for the follow reasons:

Medical Information can be discussed with
□ Patient only □ Family/Friend Name ____________________ □ Spouse/Significant Other Name ___________________
□ Other Representative ________________________

Billing Information and attempt to collect payment can be discussed with
□ Patient only □ Family/Friend Name ____________________ □ Spouse/Significant Other Name ___________________
□ Other Representative ________________________

Detailed message regarding test results can be left on answering machine
□ YES At this phone number only __________________________ □ NO

It is okay to communicate via email via my Patient Portal □ YES □ NO

Email Address: ____

Signature of Patient or Legal Rep. Date Witness Signature
PATIENT NAME: ____ DATE OF BIRTH: ________________________

REFERRING MD: ____ PHARMACY/PHONE#:___________________

MAIN REASON FOR CONSULTATION TODAY (CHIEF COMPLAINT): ___________________________________

Required: HEIGHT: ______________________ WEIGHT: ____________________

CURRENT OR CHRONIC/ONGOING GI CONDITIONS. Please list DATES.

□ Stomach ulcers □ Colon polyps □ Diverticulosis □ Gallstones
□ Colitis □ Crohn's □ Irritable Bowel Syndrome □ Colon Cancer
□ Hepatitis (inflammation of the liver, sometimes from a virus) Type: □ A □ B □ C
□ History of GI infection(s) (*which*) ____

PREVIOUS GI PROCEDURES OR IMAGING MOST RECENT DATES

□ Endoscopy of the stomach ____________________
□ Colonoscopy ____________________
□ Sigmoidoscopy in the past 5 years ____________________
□ Liver Biopsy ____________________
□ Abdominal ultrasound ____________________

GI SURGERY: □ Gallbladder surgery □ Appendectomy □ Other _______________________________________
ALL OTHER SURGERIES: ____

CURRENT OR CHRONIC/ONGOING MEDICAL CONDITIONS

□ Heart Disease □ Angina □ MI (date) ____________ □ Cardiac stent/valve replacement
□ Pacemaker □ Defibrillator □ Arrhythmia □ Valvular disease
□ Stroke (date) _______ □ Seizures □ DVT/PE (date) ________ □ Sleep apnea
□ Obesity _____ lbs □ Diabetes □ High cholesterol □ High blood pressure
□ Arthritis □ Gout □ Kidney disease □ Kidney dialysis
□ Blood transfusions □ HIV □ Cancer (type) _________ □ Immunologic disorder
□ COPD □ Asthma □ Tuberculosis □ Bleed/clot disorder
□ Psychiatric □ Other medical conditions ____

DRUG ALLERGIES (medicines, iodine, or radiology contrast)
List with reactions ____

FAMILY HISTORY
Check if your parents, grandparents, brothers, sisters or children have or had any of the following:

□ Problems like you are having □ Liver disease
□ Hereditary diseases (*list*) ____
□ **Colon cancer** (*list relationship, maternal/paternal, and age at diagnosis if known)*
____
□ Colon polyps
□ Other cancers (*list relationship, maternal/paternal, and age at diagnosis if known)*
____

SOCIAL HISTORY

□ Currently disabled Any Mobility Impairments? (i.e. wheelchair) ______________________
□ Current smoker, *how many per day?* _____ □ Former smoker, *year quit?* ________ □ Never smoked
□ Current drinker (alcohol), *how much?* _____________ per week □ Don't drink alcohol
□ Intravenous drugs not prescribed by a physician or other street drugs □ No IV or street drugs
□ Born outside the US?, *which country* ____

REVIEW OF SYSTEMS

In the last **6 months** have you experienced any of the following?

	Yes	No	Do you currently have?	Date of last Occurrence?
GENERAL	Yes	No		
	□	□	Fever/chills?	
	□	□	Unintentional weight loss? Amount: Lbs since when?	
	□	□	Fatigue / tire easily?	
EYES/MOUTH/THROAT	Yes	No		
	□	□	Eye inflammation / redness?	
	□	□	Non-healing mouth sores?	
	□	□	Sour taste in your mouth?	
	□	□	Stomach contents in your mouth?	
	□	□	Sore throat?	
	□	□	Hoarse Voice?	
	□	□	Severe tooth decay?	
CARDIAC	Yes	No		
	□	□	Chest pain or pressure?	
	□	□	Palpitations (sensation of heart beating in chest)?	
RESPIRATORY	Yes	No		
	□	□	Shortness of breath?	
	□	□	Wheezing / asthma?	
GASTROINTESTINAL	Yes	No		
	□	□	Heart burn / acid reflux?	
	□	□	Difficult / painful swallowing?	
	□	□	Nausea / vomiting?	
	□	□	Poor appetite?	
	□	□	Diarrhea (loose or frequent stools)?	
	□	□	Constipation?	
	□	□	Bloody or black bowel movements (on Iron? Pepto Bismol?)	
	□	□	Vomiting blood?	
	□	□	Significant abdominal pain or cramping?	
MUSCULOSKELETAL	Yes	No		
	□	□	Joint pain?	
	□	□	Back pain?	
SKIN	Yes	No		
	□	□	Rash?	
	□	□	Jaundice (yellowing of the skin or eyes)?	
	□	□	Easy bruising or bleeding?	
NEUROLOGICAL	Yes	No		
	□	□	Trouble thinking clearly?	
	□	□	Fainting?	
PSYCHOLOGICAL	Yes	No		
	□	□	Stress at work or home?	
	□	□	Feeling anxious or depressed?	
BLOOD/LYMPH	Yes	No		
	□	□	History of anemia?	
	□	□	Bleeding or clotting disorder?	

Initials ____________________ Date ____________________

PATIENT MEDICATION LIST

So that we may maintain the highest quality in care and safety, please fill in
ALL MEDICATIONS that you take

Please be sure to include all asthma, heart and blood pressure medications, any narcotics you may take (Percocet, etc.), and any over the counter or herbal medications, medical creams or sprays and any supplements

PLEASE PRINT LEGIBLY

	MEDICATION NAME	**DOSE (ml/mg) TIMES PER DAY**	**WHAT ARE YOU TAKING THIS MEDICATION FOR?**	**NOTES**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				

THE ABOVE NOTED LIST IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF:

Print Name   Patient Signature   Date

I do not take any medications at this time.

Print Name   Patient Signature   Date

East Bay Center for Digestive Health Medical Associates, Inc.

Paul S. Chard, M.D., Ph.D., E. Michael Darby, M.D., Thomas B. Hargrave, III, M.D. Susie Ng Cohn, M.D.,
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Direct Referral Screening Colonoscopy

General Information and Colonoscopy Consent Form

Background: In the United States, colorectal cancer (CRC) is the second leading of cancer deaths (lung cancer is the leading cancer). Approximately 150,000 new cases are diagnosed in the US every year. Screening has been shown to decrease death from CRC. Your primary care physician has referred you to have a screening colonoscopy.

What is it? Colonoscopy is a procedure that allows your physician to see the inside of your colon and rectum using a flexible tube (about the width of your index finger) containing a light and camera. This technology gives the physician the ability to take biopsies and remove suspicious findings if any are seen.

What to expect: On the day before the procedure you will not be allowed to eat ANY solid foods. However, you will be allowed to have clear liquids. Sometime during the DAY BEFORE the procedure you will begin a bowel preparation to "clean out" your colon. **Please read the bowel preparation instructions for specific further details – these are sent to you once the procedure is scheduled.**

Because this test can be mildly uncomfortable, you will be receiving some type of anesthesia to make you sleepy during the exam, but you will not lose consciousness and will be breathing on your own. Most patients do not recall having the procedures done because the sedatives can impair short-term memory. The procedure typically takes less than 30 minutes. Recovery time is typically less than 60 minutes. Due to the anesthesia you will be receiving, you will not be allowed to drive home from the procedure. **You will need a responsible adult to take you home. You cannot take a taxi or other service, i.e. Uber.**

You can have a light meal after your procedure and the remainder of the day should be spent resting. Due to the anesthesia, your judgment might be impaired for the remainder of the day, so you shouldn't make any big decisions or operate machinery. The next day you should be back to normal.

RISKS, BENEFITS, AND ALTERNATIVES: The risk of serious consequence from screening colonoscopy is very low. Potential serious complications include bowel perforation (approximately 1 in 1,000), there is a small risk of heavy bleeding after removal of polyps (approximately 1 in 1,000) and death (approximately 1 in 20,000). Other possible risks include adverse reaction to sedation, and missed lesions. Alternatives to a screening colonoscopy include a radiology test called barium enema, a flexible sigmoidoscopy, yearly stool test cards, which check for blood, and choosing not to have investigation performed.

If you have more specific questions regarding the procedure itself or the risks, benefits and alternatives, you are advised to make an office visit to fully answer all your questions before scheduling the procedure.

I acknowledge that I have been informed about screening colonoscopy and the risks, benefits and alternatives. Additionally, I understand I need to cancel my procedure at least 72 business hours in advance to avoid a cancellation fee.

______________________	______________________	__________
Print Name	Patient Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I, ___________________________________ have received a copy of the Financial Policy for Practices for East Bay Center for Digestive Health.

____
Please print name

____
SIGNATURE

____
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ___________________________________ have received a copy of the Notice of Privacy Practices for East Bay Center for Digestive Health.

____
Please print name

____
SIGNATURE

____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)____

<u>NOTIFICATION</u>

Please be informed that the physician who is rendering services to you has ownership interest in this facility.

East Bay Endosurgery was designed and built specifically to provide outpatient GI endoscopy procedures and to meet the needs of our community. Our staff consists of licensed nurses and certified technicians who are specifically qualified to assist in endoscopic procedures. The combination of our physicians and this group of dedicated professionals ensures the highest quality healthcare for our patients. By signing this document you indicate that you are aware of their ownership interest and understand that you can request that your procedure be scheduled at Summit Hospital, but have decided to have your procedure performed at East Bay Endosurgery.

Though the physician may be contracted with your specific health plan, in some cases the facility may not. <u>The insurances listed below are contracted with the facility</u>;

Aetna, Alameda Alliance, CHCN (except Blue Cross), Blue Cross, Blue Shield, Cigna, First Health, Health Net, Medicare, Medicare/Medi-Cal (as a secondary) Pacific Care, United Health Care, PHCS, Great West, Interplan, Beech Street, Tricare, Three Rivers Provider Network and PHCS.

If your particular insurance is not listed, then it is not contracted with the facility. Many insurance plans offer out-of-network benefits which allow you to use a nonparticipating facility, while others do not. In either case, East Bay Endosurgery will strive to keep your out-of-network expenses competitive with the rates charged by "in-network" hospital facilities. Please be aware that deductibles and co-insurances are due at the time services are rendered to you.

As is customary, insurance plans make a distinction between the fee the physician charges and the fee the facility charges. Per standard billing practices, your insurance will be billed two separate claims for these services.

When East Bay Endosurgery submits a claim to a non-contracted insurance, it is possible they will forward the payment directly to you because it is not "in-network". We are asking for your cooperation in making this process run smoothly. When you receive the payment for the services provided, please sign and forward the payment to our office. Please remember that you are ultimately responsible for all charges. Should you have any questions regarding your bill, please contact our billing office at (510) 763-3332, Option 1 for billing questions regarding the doctor's fee, Option 2 for billing questions regarding the facility fee.

I have read and understood the above statement.

Signed: ____________________________________ Date: ___________________