Digestive Disorders Associates

Gastroenterology

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Phone: 410-224-4887
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www.dda.net

Dear Patient:

Welcome to Digestive Disorders Associates. We understand your health is a top priority, and we appreciate the trust you showed by choosing DDA to help you.

Your appointment has been scheduled for ________________at _____________. Please arrive at least 15 minutes early to allow for a seamless check in.

Functional gastrointestinal (GI) and motility disorders have a variety of symptoms and activities, so we will rely on a lot of information from you before and during your first appointment. To ensure we have the necessary information, we have compiled this new patient packet which includes:

- ☐ Patient Interview Form (Medical History)
- ☐ Review of Symptoms
- ☐ Office Policies & Procedures Agreement
- ☐ Financial Policy
- ☐ Release of Medical Records Authorization
- ☐ Credit Card on File Authorization

Please complete this packet and bring it to your appointment, along with your:

- ☐ Insurance Card
- ☐ Picture ID
- ☐ Referral from your physician (if required)
- ☐ Pertinent Medical Records - Prior Tests and Procedures related to your visit
- ☐ Co-Pay listed for specialist

Your co-payment, if required, is due at the time of service (details of our policy are included in your packet.) We accept cash, checks, and credit cards for payment. Finally, we strongly encourage you to visit our website www.dda.net to learn more about your doctor, your condition, and other relevant information. You can also sign up for our patient portal, which will allow you to contact your physician directly, request medication refills and book appointments. If you have any questions or concerns, please feel free to call our office, 410-224-4887. If you need to cancel your appointment, please contact the office at least 24 hours in advance at 410-224-4887 to avoid a $50 missed appointment fee.

We look forward to meeting you.

Sincerely,

Digestive Disorders Associates

Directions to the offices of Digestive Disorders Associates

Annapolis Office

Ridgely Oaks Professional Center
621 Ridgely Avenue, Suite 201
Annapolis, MD 21401

From Baltimore:
- I-695 South, exit I-97 South
- I-97 to Route 50 east
- Then follow Route 50 East directions listed below

From Route 50 East:
- From Route 50E take exit 24(Rowe Blvd/Bestgate Rd)
- Turn left onto Bestgate Rd
- At first light, turn right onto N. Bestgate Rd
- Go to stop sign and turn right onto Ridgely Ave
- Ridgely Oaks is approximatley ¼ mile on the right

From Route 50 West:
- From Route 50W take exit 24B (Bestgate Rd)
- At first light, turn right onto N Bestgate Rd
- Go to stop sign & turn right onto Ridgely Ave
- ridgely oaks is approximately ¼ mile on the right

From Downtown Annapolis:
- Follow Rowe Blvd to the 2nd light
- Turn right onto melvin ave
- Go to stop light & turn left onto Ridgely ave
- Ridgely oaks is Approximately 1 mile on the left

Gambrills Office

AAMC Health Services Building
2401 Brandermills Blvd, suite 330
Gambrills, Md 21054

From Route 50East:
- take US 301/MD 3 (**exit 13**) north towards Crofton
- travel approximately 7 miles then take a left turn on to chapel lakes rd.
- The AAMC Health Services is immediately on your right

From Route 50 west:
- take US 301/MD 3 (**exit 13**) north towards Crofton
- travel approximately 7 miles then take a left turn on to chapel lakes rd.
- The AAMC Health Services is immediately on your right

FROM BALTIMORE
- Take exit for 695 –EAST TOWARDS glen Burnie

Take Exit 4 for 97 South towards Annapolis
- TRAVEL 9.8 miles on 97 south then merge onto rt 3 south towards bowie
- travel almost 4 miles and you will see the AAMC Health Services Building on your right

turn right on to chapel lake rd., the building will be immediately on your right

Chester Office

Anne Arundel Medical Center - Kent Island Facility
1630 Main Street, Suite 213
Chester, MD 21619

From Western Shore/Route 50 East:
- From Route 50E cross the Bay Bridge
- Take Exit 39B (Dominion Rd)
- Turn right at the traffic light
- Bare right and cross overpass
- take 1st left to AAMC facility
- Across from the fire station

From Eastern Shore/Route 50 West:
- Take Exit 39A (Castle Marina Rd)
- Enter Traffic circle
- bare right at the circle onto Main St
- Make first right into AAMC facility

Financial & Office Policy and Procedures

Thank you for choosing Digestive Disorders Associates (DDA) as your Gastroenterology specialty healthcare provider. We are committed to providing you and your family with the best available medical care. To keep you informed of our current office and financial policies, we require you to read and sign this agreement. We will place a signed copy in your chart, and you may keep a copy for future reference.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, we will bill your insurance carrier, although you are ultimately responsible for the entire bill. We cannot bill your insurance company unless you give us your correct insurance information.

(PLEASE INITIAL THE FOLLOWING)

________1. Your medical insurance is a contract between you and your insurance company. We are not a party to that contract, and your bill is ultimately your responsibility whether your insurance company pays or not. If your insurance carrier does not remit payment in full within 60 days, the balance will be due in full by you. If payment is made directly to you for services billed by our center, you recognize an obligation to promptly remit payment to Digestive Disorders Associates. It is your responsibility to understand your insurance policy and to know if we are participating providers with your specific plan. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, and secondary insurance charges. As your medical provider, we will only supply facility information to facilitate claim processing. **Patients must present appropriate insurance information at the time of service or the visit will be rescheduled and a cancellation fee of $50 may be charged.**

________2. **Referrals**: Patients must present a valid referral (if required) at the time of service or the visit must be paid in full or rescheduled where a cancellation fee of $50 may be charged. We do NOT contact primary care physicians for referrals. Please make sure your referral is dated, the referring physician or facility name is correct, the place of service is marked as office, and that the referral has not expired. If you are unsure of the expiration date, PLEASE verify with your primary care physician and have them mark this. (It is the PATIENT'S RESPONSIBILITY to obtain a copy of the referral for their visit.)

________3. **Cancellation**s: Our office requires a 24-hour notice for cancellation. If an appointment is not cancelled within the 24 hour notice, the patient is charged a cancellation/no-show fee of $50.00. Failure to cancel an appointment for a procedure with the MDTEC facility within 48-hours will result in a fee in the amount of $200.00. If you believe you were charged this no-show fee in error, we allow 30 days to dispute this charge. This amount will be due prior to the patient's next visit.

________4. Returned payments, and collection fees incurred by use of an outside collection agency are subject to the following fees added to the balance due: Returned payments: $35 per transaction. Collection Agency Fee: 40% of total balance transferred to collections and any additional attorney fees and costs that apply to collection

________5. Medical records request require 5 to 10 business days to process and required a signed medical records release. There is a fee for this processing mandated by Maryland State Law. This fee is $22.00 plus an additional $0.73 per page for lawyer or administrative transfers. Pre- Payment is required.

________6. **Credit Card on File**. Patients have the option of keeping credit card information on file. If there are any additional charges accessed after the insurance claim has been adjudicated, including the physician, facility, anesthesia, and pathology (lab) fees, we will use this credit card for those charges. Initials only represent that patient is aware of the option to have a credit card on file.

________7. **Co-Payments**: Co-payments **must** be paid at the time of service. This is required in the terms of your contract with your insurance company. Any amounts that are applied to the patient’s deductible are due and payable prior to the patient’s next visit or within 30 days after we receive notification from your insurance company, whichever comes first. *Self-pay patients are required to pay their visits in full at the time of service.*

________8. **Prescriptions**: Prescription refills and prior authorizations require 72 hour notice to be filled and completed. Detailed information must be left in order for this process to be completed and it is preferred that patients have their pharmacies fax over refill request on their behalf.

________9. I consent to DDA's use and disclosure of my protected health information for treatment, payment, and health care operations. I understand that I have the right to revoke this consent in writing, except where DDA has already made disclosure in trust, based on prior consent.

________10. **Consent for Treatment**: By signing this consent I am authorizing my provider, known as Digestive Disorders Associates (DDA) to perform and/or order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition.

I UNDERSTAND THE ABOVE INFORMATION AND MY SIGNATURE BELOW ATTESTS TO MY CONSENT:

Patient's Signature:____**Date:**_____________

Patient's Printed Name: ____

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

☐ I GIVE PERMISSION for **Digestive Disorders Associates** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name:______________________________ **Name:** ______________________________

Relationship:_______________________ **Relationship:** _______________________

Name:______________________________ **Name:** ______________________________

Relationship:_______________________ **Relationship:** _______________________

☐ I DO **NOT** GIVE PERMISSION for **Digestive Disorders Associates** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

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1. I understand that this authorization will expire one (1) year after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying DDA in writing.

Patient's Signature:_______________________________________ **Date:** ___________

Patient's Printed Name: ____________________________________

* Patient is a minor (____years of age) *OR is unable to give permission because: ___________________

____

Signature of Individual Signing on Behalf of Patient:____________________________**Date:** ________

Credit Card on File Authorization

Patient: ______________________________ **Account #:** ______________

AGREEMENT

Until further notice, I authorize Digestive Disorders Associates, Maryland Diagnostic & Therapeutic Endo Center, and Maryland Anesthesia Providers to charge the patient-responsible balances on my account to the following credit card:

Circle one: Visa Mastercard Discover A/E

Type: Credit HSA FSA

Card Number: ____

Exp. Date (mm/yy): ________________________

3 Digit Security Code: ____________

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB) from my insurance company. The insurance plan EOB will state any balance remaining to be paid by me. I agree that my credit card on file may be charged for the balance due at the time the copy of the EOB is received by the provider.

Signature: __________________________________ Date: ________________

Printed Name of Cardholder: _______________________________________

Date of Birth: __________________ Last 4 digits of SSN: ________________

NOTE: *Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.*

Digestive Disorders Associates

Thank you for choosing Digestive Disorders Associates to participate in your health care. While our staff is preparing for your visit, please complete these few quick questions as to the reason for today's visit.

Name:____

Reason for today's visit:____

____

Please check off the symptoms below that apply to your current problem.

Allergic/Immunologic	Yes	No
HIV Exposure	☐	☐
Persistent Infections	☐	☐
TB Exposure	☐	☐

Cardiovascular	Yes	No
Chest Pain	☐	☐
Palpitations	☐	☐

Constitutional	Yes	No
Fever	☐	☐
Loss of Appetite	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐

Eyes	Yes	No
Double Vision	☐	☐
Sensitivity to Light	☐	☐

Gastrointestinal	Yes	No
Difficulty Swallowing	☐	☐
Heartburn	☐	☐
Abdominal Pain	☐	☐
Abdominal Swelling	☐	☐
Change in Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Jaundice	☐	☐
Nausea	☐	☐
Rectal Bleeding	☐	☐
Stomach Cramps	☐	☐
Vomiting	☐	☐
Hemorrhoids	☐	☐

Hematologic/Lymphatic	Yes	No
Easy Bruising	☐	☐
Prolonged Bleeding	☐	☐

Skin	Yes	No
Rashes	☐	☐

Musculoskeletal	Yes	No
Arthritis	☐	☐
Muscle Weakness	☐	☐

Psychiatric	Yes	No
Anxiety	☐	☐
Depression	☐	☐
Difficulty Sleeping	☐	☐
Nervousness	☐	☐

Respiratory	Yes	No
Cough	☐	☐
Coughing up Blood	☐	☐
Shortness of breath w exercise	☐	☐

My local pharmacy is: ____

In order to insure that you maintain your medication regime on schedule, please be sure to request any refills that you may need before your next visit.

Medicare	Yes
	No
Appointment Type	Consult
	Follow-Up

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(410) 224-4887 **www.dda.net**
(410)224-1428 Fax

Patient Interview Form

Patient Information

First Name:______________________ Last Name:______________________
MRN:______________________ Date Of Birth:______________________
Age:______________________

Email
Please check one as your preferred email for communications

- ⬭ Personal:______________________
- ⬭ Work:______________________

Race
Select one or more

- ⬭ White
- ⬭ Black or African American
- ⬭ Asian
- ⬭ American Indian or Alaska Native
- ⬭ Native Hawaiian or Other Pacific Islander
- ⬭ Other Race
- ⬭ Unknown

Ethnicity

- ⬭ Hispanic or Latino
- ⬭ Not Hispanic or Latino
- ⬭ Patient declines to specify
- ⬭ Unknown

Sex

- ⬭ Male
- ⬭ Female
- ⬭ Other
- ⬭ Unknown

Preferred Language

- ⬭ English
- ⬭ Patient declines to specify

Contact Preference

- ⬭ Home Telephone
- ⬭ Cell Phone
- ⬭ Patient Portal
- ⬭ Patient declines to specify
- Other:__________

Allergies

- ⬭ Patient has no known allergies
- ⬭ Patient has no known drug allergies

- ⬭ Soy
- ⬭ Eggs
- ⬭ Nuts / Peanuts
- ⬭ Penicillins
- ⬭ Demerol
- ⬭ Valium
- ⬭ Amoxicillin
- ⬭ Cipro
- ⬭ Augmentin
- ⬭ Latex
- ⬭ Versed
- ⬭ Morphine
- ⬭ Aspirin
- ⬭ Sulfa (Sulfonamide Antibiotics)
- Other:__________

Current Medications

☐ None

Name	Dose	How taken?

Past or Present Medical Conditions

☐ None

General

- ☐ Open Skin Wounds or Rashes When:____ Other:____
- ☐ Organ Transplant Recipient When:____
- ☐ Previous Organ Donor When:____
- ☐ Sexually Transmitted Diseases When:____

Cardiac & Vascular

- ☐ None (Cardiac or Vascular) When:____
- ☐ Implanted Pacemaker When:____
- ☐ Implanted Defibrillator When:____
- ☐ Congestive Heart Failure / Enlarged Heart When:____
- ☐ Atrial Fibrillation When:____
- ☐ Heart Murmur When:____
- ☐ Chest / Heart Pain When:____
- ☐ Mitral Valve Prolapse When:____
- ☐ Heart Attack When:____
- ☐ Hypertension / High Blood Pressure When:____
- ☐ Vascular Disease When:____
- ☐ Deep vein thrombosis When:____
- ☐ Venous Access Device When:____
- Other:____

Pulmonary

- ☐ None (Pulmonary) When:____
- ☐ Use Oxygen at Home When:____
- ☐ COPD When:____
- ☐ Emphysema When:____
- ☐ Asthma When:____
- ☐ Tuberculosis When:____
- ☐ Sleep apnea When:____
- Other:____

Neurological

- ☐ None (Neurologic) When:____ Other:____
- ☐ CVA / Stroke When:____
- ☐ Seizures When:____
- ☐ Altered Mental Status When:____

Endocrine

- ☐ None (Endocrine) When:____
- ☐ Diabetic-Managed with Insulin When:____
- ☐ Diabetic-Managed with Oral Medication When:____
- ☐ Use Insulin Pump When:____
- ☐ Graves Disorder When:____
- ☐ Hyperthyroidism When:____
- ☐ Hypothyroidism When:____
- Other:____

Hematologic / Cancer / Infections

- ☐ None (Hematologic / Cancer / Infection) When:____
- ☐ Radiation to the Head, Neck, Throat or Chest When:____
- ☐ Taking Blood Thinner Medication / Anticoagulant When:____
- ☐ Anemia When:____
- ☐ Bleeding Disorder When:____
- ☐ Blood Transfusion History When:____
- ☐ Diagnosed with Cancer When:____
- ☐ Diagnosed with Colon Cancer When:____
- ☐ Lung cancer When:____
- ☐ Liver Cancer When:____
- ☐ Esophageal Cancer When:____
- ☐ Chronic Infectious Disease When:____

- ◯ HIV When:______________
- ◯ Prostate Cancer When:______________
- ◯ Melanoma / Skin Cancer When:______________
- ◯ Basal Cell Carcinoma When:______________

Gastrointestinal

- ◯ None (Gastrointestinal) When:______________
- ◯ Liver Disease When:______________
- ◯ Hepatitis A When:______________
- ◯ Hepatitis B When:______________
- ◯ Hepatitis C When:______________
- ◯ Other Hepatitis When:______________
- ◯ Barretts Esophagus When:______________
- ◯ Acid Reflux / GERD When:______________
- ◯ Chronic Diarrhea When:______________
- ◯ Ulcer When:______________
- ◯ Hiatal Hernia When:______________
- ◯ Colostomy / Ileostomy / PEG Tube When:______________
- ◯ Ulcerative Colitis When:______________
- ◯ Crohn's Disease When:______________
- ◯ Irritable Bowel Syndrome When:______________
- ◯ Colon Polyps When:______________
- ◯ Stomach Polyps When:______________
- ◯ Cirrhosis When:______________
- ◯ Diverticulitis When:______________
- ◯ Gallstones When:______________
- ◯ Pancreatitis When:______________
- Other:______________

Genitourinary

- ◯ None (Genitourinary) When:______________
- ◯ Kidney Failure When:______________
- ◯ Currently on Hemodialysis When:______________
- ◯ Currently on Peritoneal Dialysis When:______________
- ◯ Kidney Disease When:______________
- Other:______________

Musculoskeletal

- ◯ None (Musculoskeletal) When:______________
- ◯ Back Pain (Chronic) When:______________
- ◯ Significant Neck Problems When:______________
- ◯ Arthritis When:______________
- ◯ Gout When:______________
- ◯ Metal in your body When:______________
- ◯ Fibromyalgia When:______________
- Other:______________

Mental / Emotional

- ◯ None (Mental / Emotional) When:______________
- ◯ Bipolar Disorder When:______________
- ◯ Alzheimer's When:______________
- ◯ Anxiety Disorder When:______________
- ◯ Dementia When:______________
- ◯ Depression When:______________
- ◯ Psychiatric Diagnoses When:______________
- Other:______________

Mobility / Vision / Hearing / Assistive Devices

- ◯ None (Assistive Devices) When:______________
- ◯ Currently Use a Cane or Walker When:______________
- ◯ Currently Use Wheelchair When:______________
- ◯ Currently Use Crutches When:______________
- ◯ Have Prosthetic Device When:______________
- ◯ Use Hearing Aids When:______________
- ◯ Wear Glasses When:______________
- ◯ Wear Contact Lenses When:______________
- ◯ Glaucoma When:______________
- ◯ Wear Dentures When:______________

Previous Procedures

- ◯ None

- ◯ Implanted Cardiac Defibrillator When:______________
- ◯ Pacemaker Insertion When:______________
- ◯ Heart Valve Replacement When:______________
- ◯ Cardiac Stent When:______________
- ◯ Cardiac Surgery When:______________
- ◯ Angioplasty When:______________
- ◯ Coronary artery bypass surgery When:______________
- ◯ Carotid Stent When:______________
- ◯ Colon Resection When:______________
- ◯ Appendectomy When:______________
- ◯ Gallbladder removed When:______________
- ◯ Gastric Band When:______________
- ◯ Gastric By-Pass When:______________
- ◯ Hemorrhoidectomy When:______________
- ◯ Hernia Repair When:______________

- C-Section When:______________
- Hysterectomy When:______________
- Joint Replacement When:______________
- Mastectomy When:______________
- Prostatectomy When:______________
- Surgery When:______________
- Other: When:______________

Immunizations

- None

- Hep A When:______________
- Hep B When:______________
- Flu (MM/DD/YYYY) When:______________
- Pneumonia (YYYY) When:______________

Diagnostic Studies/Tests

- None

- Annual Labs When:______________
- Colonoscopy When:______________
- Duodenum Biopsy When:______________
- EGD When:______________
- ERCP When:______________
- Esophageal Biopsy When:______________
- Liver Biopsy When:______________
- Stomach Biopsy When:______________

Social History

Occupation:____ Number of Children:_________________________________

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Civil Union
- Unknown
- Other

Alcohol

- None

- Rarely
- Daily
- More than 2 days/week
- Less than 2 days/week
- I quit using alcohol

Type:____

Caffeine

- None

- Intake:____

Tobacco

Smoking Status

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Light tobacco smoker
- Heavy tobacco smoker
- Unknown if ever smoked

Type:____

Drug Use

- None

- I am currently using recreational drugs
- I have used recreational drugs in the past
- I have been treated for substance abuse

Type:____

Exercise

- None

Type	Frequency

Family Medical History

○ No knowledge of family history

No family history of ○ Colon cancer ○ Polyps

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Diagnoses						
Ulcer Disease	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Colitis	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○

Pharmacy

Name Address Phone

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- [ ] Yes
- [ ] No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

- [ ] Yes
- [ ] No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

- [ ] Yes
- [ ] No

Reviewed with

- [ ] Patient
- [ ] Parent
- [ ] Guardian
- [ ] Not Present

Signature

Signature Date