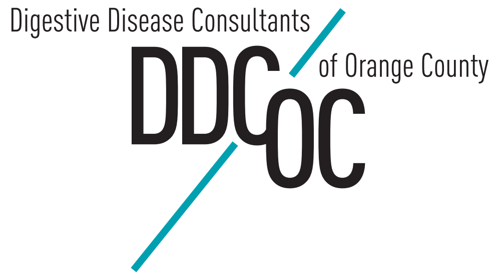



**DDCOC- Irvine**
113 Waterworks Way, Ste. 155
Irvine, CA 92618

**DDCOC- Huntington Beach**
19582 Beach Blvd., Ste. 270
Huntington Beach, CA 92648

**DDCOC- Tustin**
15000 Kensington Park, Ste. 270
Tustin, CA 92782

**DDCOC- Fountain Valley**
18785 S. Brookhurst St, Ste. 200
Fountain Valley, CA 92708

www.DDCOC.com | contact@ddcoc.com
office 949-612-9090 | fax 949-612-9091

*Welcome to our practice!*

Please print the attached forms and complete all the requested information prior to your office visit.

You may also fill out the paperwork through our Patient Portal prior to your appointment. Please call the office so we can assist you with access to the portal.

*Thank you.*

## AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT BENEFITS

**Consent to Import Medication History** ☐ Yes ☐ No
I consent to obtaining a history of my medications purchased in pharmacies.

**Consent to Share Data** ☐ Yes ☐ No
I consent to having my medical and demographic information shared with other health care entities.

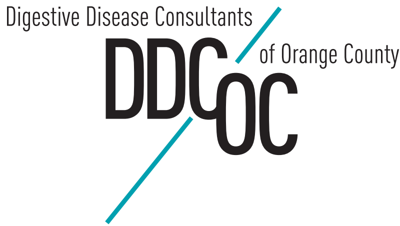
**Reminder Preference** ☐ Yes ☐ No
I would like to receive preventive care and follow up care reminders

*Reviewed with:* ☐ Patient ☐ Parent ☐ Guardian

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize DDCOC, Inc to apply for benefits on my behalf for covered services rendered by the doctors that belong to DDCOC. I request that payment from my insurance company be made directly to DDCOC (or to the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. Either my insurance company or I may revoke this authorization at any time in writing.

______________________________ ____________________
SIGNATURE DATE

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# PATIENT MEDICAL HISTORY

## PATIENT REGISTRATION

patient name: **LAST, FIRST** ☐ Male ☐ Female

**DOB** **SSN** driver's license

address: **STREET** **CITY** **STATE** **ZIP**

phone: **HOME** **CELL**

primary email

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Specify

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Native Hawaiian ☐ Unknown ☐ Decline to Specify

PREFERRED METHOD OF CONTACT: ☐ Letter ☐ Email ☐ Phone ☐ Other:____________________ ☐ Decline to Specify

PREFERRED PHARMACY **CITY** **PHONE**

PRIMARY DOCTOR REFERRING PROVIDER (If different from Primary Doctor)

## EMERGENCY CONTACT

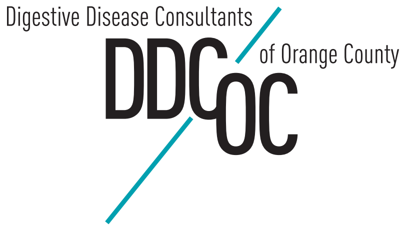
name: **LAST, FIRST** relation to patient **PHONE**

## INSURED PERSON

name: **LAST, FIRST** relation to patient **SSN**

**#1** PRIMARY INSURANCE CO. ID #

**#2** SECONDARY INSURANCE CO. ID #

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# PATIENT MEDICAL HISTORY

## MEDICATION ALLERGIES & REACTIONS

☐ No known drug allergies ☐ Penicillin ☐ Sulfa
☐ Latex Gloves ☐ IV Dye Iodine ☐ Other ______________________

## MEDICATIONS

| NAME | DOSE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## IMMUNIZATIONS

☐ Pneumovax, When: ____________________________________

## FAMILY HISTORY

☐ No knowledge of Family History

**DIAGNOSES:** Please list the diagnosed Parent, Sibling, or Grandparent, and the AGE at their diagnosis.

Colon Cancer: ☐ __________________________________________________
Esophageal Cancer: ☐ __________________________________________________
Lynch Syndrome: ☐ __________________________________________________
Stomach Cancer: ☐ __________________________________________________
Colon Polyps: ☐ __________________________________________________
Liver Cancer: ☐ __________________________________________________
Pancreatic Cancer: ☐ __________________________________________________
Uterine Cancer: ☐ __________________________________________________
Inflammatory Bowel Disease: ☐ __________________________________________________

## SOCIAL HISTORY

______________________________________________________________________
occupation

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Alcohol
☐ None ☐ Occasionally ☐ Daily

Tobacco
☐ Current smoker ☐ Former smoker ☐ Never smoked

Drug Use
☐ Yes ☐ No

Digestive Disease Consultants of Orange County

DDCOC

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# PATIENT MEDICAL HISTORY

## PAST OR PRESENT MEDICAL CONDITION

☐ None

**GASTROENTEROLOGY/ HEPATOLOGY**

☐ Hep A ☐ Hep B ☐ Hep C
☐ H. Pylori Infection ☐ Ulcer ☐ Hemorrhoids
☐ Colon Cancer ☐ Jaundice ☐ Irritable Bowel Syndrome
☐ Diverticulitis ☐ Crohn's Disease ☐ Ulcerative Colitis
☐ Cirrhosis ☐ Celiac Disease ☐ Bowel Obstruction
☐ Pancreatitis ☐ Fatty Liver ☐ Barrett's Esophagus
☐ Gastresophagael Reflux Disease (GERD) ☐ Other ______________

**CARDIOLOGY**

☐ Heart Disease ☐ High Blood Pressure ☐ Coronary Artery Disease
☐ Coronary Artery Stents ☐ Heart Attack ☐ Atrial Fibrilation
☐ Other ___________

**PULMONOLOGY**

☐ Asthma ☐ C.O.P.D. ☐ Sleep Apnea ☐ Other ______________

**OTHER**

☐ Diabetes ☐ Anxiety Disorder ☐ Bipolar Disorder ☐ Seizures

## PRIOR DIAGNOSTIC STUDIES/TESTS

☐ None

☐ Colonoscopy DATE ________________________________
☐ EGD DATE ________________________________
☐ CT Abdomen/Pelvis DATE ________________________________
☐ MRI Abdomen/Pelvis DATE ________________________________
☐ ERCP DATE ________________________________

## PREVIOUS SURGERIES

☐ None

☐ Gallbladder Removed ☐ Appendectomy ☐ Colon Resection ☐ Small Bowel Resection
☐ Exploratory Laparotomy ☐ Gastric Bypass ☐ Gastric Lap Band

## REVIEW OF SYSTEMS

**GASTROINTESTINAL** ☐ None
Abdominal Pain ☐ Y ☐ N
Change in Bowel Habits ☐ Y ☐ N
Constipation ☐ Y ☐ N
Diarrhea ☐ Y ☐ N
Excessive Gas ☐ Y ☐ N
Heartburn ☐ Y ☐ N
Nausea ☐ Y ☐ N
Blood in Stool ☐ Y ☐ N
Vomiting ☐ Y ☐ N
Bloating ☐ Y ☐ N
Hemorrhoids ☐ Y ☐ N

**EYES** ☐ None
Blurred Vision ☐ Y ☐ N

**CARDIOVASCULAR** ☐ None
Chest Pain or Pressure ☐ Y ☐ N
Irregular Heart Beat ☐ Y ☐ N

**RESPIRATORY** ☐ None
Cough ☐ Y ☐ N
Shortness of Breath ☐ Y ☐ N

**GENITOURINARY** ☐ None
Kidney Disease ☐ Y ☐ N

**CONSTITUTIONAL** ☐ None
Fatigue ☐ Y ☐ N
Weight Loss ☐ Y ☐ N

**ENT** ☐ None
Hearing Loss ☐ Y ☐ N
Ringing in Ears ☐ Y ☐ N

**NEUROLOGICAL** ☐ None
Dizziness ☐ Y ☐ N
Fainting ☐ Y ☐ N

**ALLERGIC/IMMUNOLOGIC** ☐ None
Immune Deficiency ☐ Y ☐ N

**MUSCULOSKELETAL** ☐ None
Arthritis ☐ Y ☐ N

**PSYCHIATRIC** ☐ None
Anxiety ☐ Y ☐ N

**INTEGUMENTARY** ☐ None
Itching ☐ Y ☐ N

**HEMATOLOGIC/LYMPHATIC** ☐ None
Anemia ☐ Y ☐ N
Bleeding Disorder ☐ Y ☐ N
Clotting Disorder ☐ Y ☐ N

# OFFICE AND FINANCIAL POLICY

Thank you for choosing our practice. We are committed to providing the best possible medical care for you. In order to avoid any confusion, we ask that you read the following Office and Financial Policy carefully.

**Insurance Billing:**
Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they would apply to your treatment. We will bill your insurance for services that we provide; however, any account balance that is not paid by your insurance company will be your responsibility (or the responsibility of the guarantor listed on your insurance policy).
*All deductibles and co-payments will be collected in full at the time of service.

**No Show Fee Policy (Office Appointments & Procedures):**
We understand that situations arise in which you may need to cancel your appointment. It is therefore requested that you notify our office at least **24 hours in advance** if you are unable to keep your scheduled **office** appointment AND **72 hours in advance** for scheduled **procedure** appointments. This may enable us to utilize that spot for another patient who may be waiting for an appointment.

- **Office appointments** which are cancelled with less than 24 hours' notification may be subject to a **$50.00 cancellation fee**. Patients who do not show up to their office appointment are considered a **No-Show** and are subject to a **$50.00 office appointment no-show fee**.
- **Procedure appointments** which are cancelled with less than 72 hours' notification may be subject to a **$200.00 cancellation fee**. Patients who do not show up for their procedure(s) will be considered a **No-Show** and are subject to a **$200.00 procedure appointment no-show fee**.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

**Phone Consultations:**
Routine phone consultations will not be performed by our physicians and healthcare providers. After-hour phone calls are limited to urgent medical issues. All other medical matters (including test results) must be discussed in the office. We'll make every effort to notify you with test results; however, it is the patient's responsibility to call for any test results.

**Administrative Fees:**
All medical record requests are subject to a preparation fee of **$15.00**. We encourage that you sign up for portal access where you can access your records without a charge.

- All administrative forms (i.e. disability, employer's leave, etc) are subject to a **$45.00 fee**.

**Cash Patient Policy:**
If you do not have (or wish not to use) health insurance for your office visit, you are considered a 'Cash Patient'.

- All Cash Patients must pay a $50.00 non-refundable fee to book office appointments. This fee will be applied towards your balance.
- All Cash Patients must pay their physician-fee portion of their procedure(s) in full prior to scheduling their procedure(s).

**Acknowledgement and Authorization:**
I have read, understand, and agree to abide by the above Office and Financial Policy.

**MY SIGNATURE ACKNOWLEDGES RECEIPT OF THIS FORM** **DATE**

# NOTICE OF PRIVACY POLICIES

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 INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

**Introduction**: Our practice is committed to treating and using your protected health information responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information as defined by federal regulations.

**Understanding Your Health Record**: Each time you visit our practice, a record is made of your visit. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify the service billed were actually provided
- A source of data for medical research
- A source of information for public health charged with improving the health of the state and the nation
- A source of data for our business planning
- A tool with which we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used, helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information. It will also allow you to make informed decisions when authorizing disclosure to others.

**Your Health Information Rights**: Although you health record is the physical property of DDCOC Inc the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record. You must submit your request in writing.
- Amend your health record. Your request must be submitted and contain reasons to support your request.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities**– DDCOC Inc. is required to:

- By law maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us with or if you agree by e-mail or fax.

We are permitted by law to disclose your health information for Treatment, Payment, and Health Operations: For any other disclosure of your health information we are required to obtain your written authorization. For example we would need your written authorization to give your health information to a healthcare insurance company that you apply to for health insurance coverage.

For More Information or to Report a Problem: If you have question sand would like additional information you may contact us at (949) 612-9090.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or with the Office for Civil Rights. The OCR can be contacted at: Office for Civil Rights, U.S. Dept. of Health and Human Services, 200 Independence Ave., S.W., Room 509F HHH Building, Washington D.C. 20201.

Examples of Disclosure for Treatment, Payment and Health Operations: We will use your health information for treatment. For Example: Information obtained by a nurse, physician or other member of our staff will be recorded in your medical record and used to determine your course of treatment. We will then provide your referring physician or a subsequent healthcare provider with copies of these reports that should assist him or her in treating you.

We will use your health information for regular health operations. For Example: Members of our medical staff, the risk or quality improvement manager may use information in your health record to assess the care and outcomes in your care and other like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include our billing software vendor and the clearing house who handles the electronic transmission of our claims. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do. To protect your health information, however, our business associate is required to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We may also use and share with third parties your e-mail address as well as other contact information as communication tools in attempt to keep you informed about up and coming information regarding products and services which in our opinion may be of interest and of potential benefit to you. If you any reason you would not like your contact information shared and would not like to receive any such information, you may simply opt out by contacting us at 949) 612-9090.

Communication with Family: Health Professionals using their best judgment may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your cares.

Appointment Reminders: We may disclose and use your health information to contact you to provide appointment reminders.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or past marketing surveillance information to enable product recalls, repairs or replacement.

Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established y law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be release to an appropriate health oversight agency, public health authority or attorney.

/

**MY SIGNATURE ACKNOWLEDGES RECEIPT OF THIS FORM / DATE**