North Coast Endoscopy, Inc.
9500 Mentor Avenue
Mentor, Ohio 44060

Name:_____ **Date:** _____ **Number:** _____

Dear Patient, welcome to our practice, please take a few minutes to complete the following to the best of your knowledge. (check when appropriate)

Chief Complaint: (The reason that brought you here)_____

For how long have you had the problem?:_____

Modifying Factor (Food, hunger, sleep, etc.) _____

Severity: (1-10)_____

Your Medical History: Do you, or **did** you have any of the following:? (**please check**)

High Blood Pressure	☐	Stroke	☐	Hemorrhoids	☐
Low Blood Pressure	☐	Hepatitis	☐	Ulcers	☐
Heart Disease	☐	Jaundice	☐	Colon Polyps	☐
Anemia	☐	Blood Transfusion	☐	Sleep Apnea	☐
Diabetes		Tuberculosis		Asthma	☐
Arthritis	☐	Thyroid Disease	☐	Emphysema	☐
Depression	☐	Kidney Disease	☐	Seizures	☐
Hernia	☐	Cancer	☐	HIV/AIDS	☐
	☐		☐		

Others_____

Your Digestive History:

Previous Colonoscopy or Endoscopy? No ☐ Yes ☐ When?_____Where?_____
By Whom?_____

Recent Barium Studies? (Upper or Lower GI's)?_____

Your Surgical History and/or Recent Hospitalizations:

Heart Surgery_____ Gall Bladder_____
Cardiac Catherization_____ Hysterectomy_____
Hernia_____ Others_____

Your Medications:

1.)_____Dose_____Frequency_____ 4.)_____Dose_____Frequency_____
2.)_____Dose_____Frequency_____ 5.)_____Dose_____Frequency_____
3.)_____Dose_____Frequency_____ 6.)_____Dose_____Frequency_____
Over the Counter_____ Blood Thinners_____

Any Allergies to the following? ☐

1) Demerol	No ☐	Yes ☐	Type of reaction_____
2) Versed	No ☐	Yes ☐	Type of reaction_____
3) Valium	No ☐	Yes ☐	Type pf reaction_____
4) Penicillin	No ☐	Yes ☐	Type of reaction_____
5) Novocaine	No ☐	Yes ☐	Type of reaction_____
6) Latex	No	Yes	Type of reaction_____
7) Diprovan	No ☐	Yes ☐	Type of reaction_____
8) Other_____			

Adverse reactions to Anesthesia? No ☐ Yes ☐

Do you Smoke? No ☐ Yes ☐ How much?_____For how long?_____Recently Quit_____
Alcohol No ☐ Yes ☐ How many drinks per week? _____
Drugs No ☐ Yes ☐
Pregnant? No ☐ Yes ☐ Last Menstrual Period_____

Please let our office know of any recent labs/X-rays/procedures that we can obtain for the doctor to review if necessary during your visit today. No ☐ Yes ☐

Your **Family History:** **Any History of Cancers/ Liver Disease?**

Father	No ☐	Yes ☐	Type_____
Mother	No ☐	Yes ☐	Type_____
Siblings	No ☐	Yes ☐	Type_____
Siblings	No ☐	Yes ☐	Type_____
Children	No ☐	Yes ☐	Type_____

Do you experience the following: (Please check)

Digestive Problems:	**YES**	**NO**
Trouble swallowing	☐	☐
Heartburn	☐	☐
Sour taste in the mouth	☐	☐
Regurgitation	☐	☐
Bloating	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Excessive Flatulence	☐	☐
Poor Appetite	☐	☐
Weight loss	☐	☐
Abdominal pain	☐	☐
Change in bowel habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Black stools	☐	☐
Rectal bleeding	☐	☐

	YES	**NO**
Cardiopulmonary:		
Chest pain	☐	☐
Shortness of breath	☐	☐
Difficulty walking	☐	☐
Cough	☐	☐
Phlegm	☐	☐
NeuroMuscular:		
Fatigue	☐	☐
Muscle weakness	☐	☐
Joint Aches	☐	☐
Psychiatric:		
Depression	☐	☐
Insomnia	☐	☐

(For online use only):
I certify to the best of my knowledge that the above is true: **YES** ☐ **NO** ☐

(For hard copy use):

_____ _____

Signature **Date**

NORTH COAST ENDOSCOPY, INC.

PATIENT REGISTRATION

Patient Name_____[ ] Male [ ] Female [ ] Transgender Birth date:__/__/__

Address:_____City_____State:_____Zip_____

Home Phone:_____Work Phone:_____Social Security #___-___-_____

Employer/School_____Occupation:_____

Marital status: [] Single [] Married [] Divorced [] Widowed

For minors: child lives with _____

Mother/Guardian:_____Address (if different) _____

Date of Birth:_____Home Phone:_____Work Phone: _____

Father/ Guardian:_____Address (if different) _____

Date of Birth_____Home Phone:_____Work Phone: _____

Referring Physician:_____

May we leave a message at your home with other residents? [] Yes []No On your answering machine/voice mail? [] Yes [] No

E-mail address_____**Can we communicate with you via the Internet? [] Yes [] No**

Other Physician:_____**May we provide him/her with update information [] Yes [] No**

Who may we talk to about your medical concerns _____

Is this contact only for emergency purposes only? [] Yes [] No, you can talk to this person whenever needed

Relationship_____Phone:_____

Responsible party for insurance and bills: [] Patient [] Spouse [] Parents [] Mother [] Father []Other_____

Obtain copy of Driver's license [] Yes [] No

Primary Insurance Company:_____Name on contract_____

Relationship to card holder: [] Self [] Spouse [] Dependent If Spouse: D.O.B. __/__/__ and SSN _____

Co-payment; $_____

Secondary Insurance Company_____Name on Contract:_____

Contract Number:_____Card holder: [] Self [] Spouse []___If Spouse: D.O.B. __/___/__ SSN_____

Identification of other physicians/health care entities involved with my medical care whom I authorize ongoing release of information for continuity of care:

Provider/s:_____Phone:_____

Address:_____Zip:_____

Type of physician/ health care provided:_____

Name of Person Completing Form _____ **Relationship to Patient**_____

I certify to the best of my knowledge that the above is true: YES ☐ NO ☐

North Coast Endoscopy, Inc.

PATIENT'S FULL NAME:

ADVANCE DIRECTIVE ACKNOWLEDGEMENT

PLEASE READ THE FOLLOWING FOUR STATEMENTS REGARDING YOUR RIGHTS TO EXECUTE AN ADVANCE DIRECTIVE (LIVING WILL OR DURABLE POWER OF ATTORNEY)

1. I have been offered written materials about my right to accept or refuse medical treatment.
2. I have been informed of my rights to formulate a Living Will or Durable Power of Attorney.
3. I understand that I am not required to have either a Living Will or Durable Power of Attorney In order to receive medical treatment.
4. I understand that the terms of any Advance Directive that I have executed will be followed by the Health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK THE FOLLOWING STATEMENT:

I HAVE executed a Living Will or Durable Power of Attorney **YES** ☐ **NO** ☐

If YES ===➔ Copy Enclosed ☐ Not Enclosed ☐

Signature (Patient or Designee)_____ Date_____

(For hard copy use only)

*Relationship if not Patient*_____

ADVANCED BENEFICIARY NOTICE RE: Screening Colonoscopy

Medicare will cover a screening colonoscopy for average risk **once every 10 years.** Medicare will cover for a shorter time period if you have family history, polyps or symptoms. If you are **NOT a Medicare recipient,** a screening colonoscopy will be covered according to your insurance plan. Please note that most insurance companies cover the expense of a screening colonoscopy.

I, the undersigned, acknowledge that I have read the above and that I will be responsible in case Medicare or my insurance company **does not** cover the cost of the procedure.

Signature_____ Date_____

(For hard copy use only)

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned acknowledge that I have received a copy of North Coast Endoscopy, Inc./ Ahmad Ascha, MD. Notice of Privacy Practices.

Signature_____ Date_____

(For hard copy use only)

DISCLOSURE NOTICE: North Coast Endoscopy is solely owned by Ahmad Ascha, M.D.

(For online use only):

I certify to the best of my knowledge that the above is true: **YES** ☐ **NO** ☐

NORTH COAST ENDOSCOPY
9500 MENTOR AVENUE, MENTOR, OH 44060
PROTECTED HEALTH INFORMATION CONSENT

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to North Coast Endoscopy, Inc. (the practice) to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize North Coast Endoscopy, Inc., (the practice) and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care.

Consent related to the Privacy Notice: I have had a chance to review and Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice **may refuse** me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may **refuse further services** at that time. If I revoke this consent, the revocation does not take effect until the practice receives it.

Patient/Guardian_____ Date: _____

Name printed:_____If not patient, relationship: _____

Copy of Practice Privacy statement signed or initiated with patient/guardian on: _____

Patient unable to sign privacy statement due to: _____

Revocation:

I hereby revoke the consent given above:

Patient/Guardian_____(For hard copy use only) Date:_____

Name printed:_____If not patient, relationship:_____

Ahmad Ascha, M.D./North Coast Endoscopy, Inc.

FINANCIAL POLICY

Thank you for choosing our medical practice for your health care needs. We are committed to providing the very best medical care. The following is a statement of our Financial Policy, which we ask you to read, agree to, and sign prior to treatment or consultation. Our Financial Policy applies to all services rendered by our practice.

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive medical care from our practice. If needed, you are responsible for securing the necessary written referrals, or pre-authorizations from your primary care physician or health plan prior to services rendered. Pre-certifications are not a guarantee of payment from your health insurance carrier. ***All patients must provide their insurance card(s) and a photo ID to the Receptionist at the time of check-in.***

Self-Pay Patients: Patients without insurance coverage are expected to pay for all services received, in full, at the time of service. Our billing department can provide you with an estimate upon request.

Non-Covered Services: Please be aware that some – and sometimes all – of the services you receive may be non- covered or not considered reasonable or deemed necessary by your insurer.

Anesthesia Services: These are a separate service provided by Heritage Anesthesia, LLC. It is the patient's responsibility to verify coverage for anesthesia services. Heritage Anesthesia phone number 440-223-2026.

Claim Submission: Our practice accepts insurance from most major insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that you will be responsible for any portion of your bill which is denied.

Payments of deductibles, co-pays and co-insurance are expected at the time of service.

Billing Statement: Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money. Therefore, the amount shown in the "Patient Amount Due" column is your obligation and is due and payable in full on or before the due date shown. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments. We realize that people may have financial difficulties. Therefore, a payment plan may be arranged by contacting our Billing Department. Accounts over 90 days past due will be closed to any future appointments and sent to our Collection Division for review as to what steps our office should take on this account. We reserve the right to terminate our relationship should an account be turned over to Collection. Should any account be referred to Collection the undersigned agrees to pay reasonable attorney's fees and an 18% collection expense. All delinquent practice accounts bear interest at a rate permitted by applicable law.

Assignment of Benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation.

Patient/Guardian Signature: _____ Date: _____
(For hard copy use only)

(For online use only): I certify to the best of my knowledge that the above is true: **YES** ☐ **NO** ☐

North Coast Endoscopy, Inc.
Practice Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TOT HIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. **This is a formal notification, as required by the government, concerning the privacy policy of this practice.** This practice has an obligation to maintain information in the strictest of confidence. Our practice cannot release information without your written consent, including conversations, reminder calls, test results, and other
confidential issues. Patient information about health care is identified as "PHI" or protected health information. This new policy requires that you, the patient, identify at the time of the registration with us specific direction about release information. **You can change this information at any time with either written or verbal notification, followed up in writing.**

II. Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations under our immediate care for care needs. This may include any office visits, such as injections, referral for diagnostic tests or services related to hospital or nursing home care.
- For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes, or operative notes. This would include eligibility verifications, prior authorization, and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form.
- Disclosure to your family and friends concerning any related health care information, with your consent on the registration form, which can be modified at any time orally, followed by written consent.
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.**

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies. An example would be a victim of abuse.
- Information used for public health agencies, medical examiners, or related to a person's death or for the health department for disease tracking, or specific government functions.
- Information used for health care oversight, such as a site review by an insurance program.
- Workers compensation and/or employer paid exams.

III. Your rights for your health information include: The rights to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see an obtain copies of your OHI, but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.

IV. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

V. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Practice Administrator at our business office to resolve your concerns or you may contact the Office of Civil Rights or Department of Health and Human Services.

Office of Civil-Rights – Regional Manager
Department of Health and Human
Services 233 N. Michigan Avenue, Suite
240

North Coast Endoscopy
PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

- The patient has the right to be informed of their rights prior to their procedure and at the time of admission.
- All patients have the right to privacy, confidentiality and to be free from all forms of abuse or harassment.
- Be treated with consideration, courtesy, dignity and respect.
- High-quality medical services provided by a competent and properly credentialed and supervised medical staff and upon request, to receive adequate information about the person(s) responsible for the delivery of their care, treatment and services.
- Know the names and title of the medical office staff who directly participate in providing their medical care and upon request, be given the credentials of all health care professionals involved in their care.
- The patient has the right to be provided with appropriate information regarding the absence of malpractice insurance coverage.
- Confidentiality of medical and financial information maintained by the office. Release of such information will be subject to the patient's approval, except when release is required by law.
- Be provided medical information concerning their treatment, diagnosis and prognosis. When, because of concern for the patient's health, it is inadvisable to provide this information directly to the patient it will be made available to an individual designated by the patient of the legally authorized person.
- Review your medical record without charge, Obtain a copy of your medical record for which the facility can charge a reasonable fee. They cannot be denied a copy solely because they cannot afford to pay.
- Participate in decisions involving their health unless outweighed by concerns for the patient's health. Patients and, when appropriate, their families are informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.
- The patient has the right to refuse informed consent. No further needs and preferences, compliance with state law and regulation, patient education, nor medical treatment will continue if patient refuses informed consent.
- Know the range of services available from the medical office as well as the provisions for after hours and emergency coverage.
- Be informed of their option to change primary of specialty physicians if they so choose.
- Coordination and continuity of their care. This includes referrals to other health care providers when indicated.
- Refuse to participate in clinical investigations or experimental research.
- Be informed of the fees for various office services as well as the office's policies for payment of these fees and to receive an itemized bill and explanation of all charges.
- Personal privacy. Patients will be clothed or covered to the extent possible while undergoing treatment or procedures and will not be exposed to noninvolved staff, visitors, or other patients.
- Communicate with office staff in a language the patient understands.
- The patient who has vision needs, such as blindness, will have all documents read to them in full detail in the presence of a witness.
- Fair and accurate marketing and advertising of office competencies and capabilities.
- Complain without fear of reprisals about the care and services received and to have the facility respond to you and if you request it, a written response. If you are not satisfied with the facilities response, you can complain to the Ohio Department of Health whose information is provided below. Patients have the right to express their grievances to the office staff. Patients will be afforded an avenue for recommending changes in office policies and services via patient satisfaction surveys.
- Considerate and respectful care given by competent personnel without discrimination based upon age, race, color, religion, spiritual and personal beliefs and preferences, sex, sexual orientation, gender identity, national origin, source of payment, handicap, disability, or any legally protected status. The patient has the right to high quality care and high professional standards that are continually maintained and reviewed.
- The patient has the right to be transferred to an acute care facility if there are complications or an emergency occurs. The patient has the right to except emergency procedures to be implemented without unnecessary delay.
- The patient has the right to receive relief from pain.

PATIENT RESPONSIBILITIES

- Provide complete and accurate information which supports their medical diagnosis, treatment and care. This includes disclosure of current medications or drugs including dietary supplements, know allergies, past medical history, hospitalizations and an accurate description of symptoms associated with the present compliant or problem.
- Patients are expected to keep appointments or telephone the center when they cannot keep a scheduled appointment.
- It is the patient's responsibility to follow the treatment plan specified by their physician and cooperate with physician and office staff while undergoing treatments and procedures. Also to provide specimens necessary for diagnosis and treatment.
- Duly authorized members of the patient's family are expected to be available to personnel for review of the patient's treatment in the event that the patient is unable to communicate with the physician or nurses.
- Following the physician and office staff instructions and orders which have been prescribed in the treatment and care of the patient's condition.
- Obtain and take prescribed medications and follow self-care instructions.
- Interact with the office staff in a businesslike and courteous manner.
- Communication between the patient and the center's team is an important element in good health care. Patients are encouraged to provide input on the care they receive. If the patients are concerned about or displeased with any aspect of their care, they should contact the nurse administrator.
- Provide complete and accurate biographical and third party pay or information to enable the office to bill collect patient charges.
- Accept accountability for prompt payment of charges for office medical services rendered.
- Patients are responsible for providing a responsible adult to transport them home from the facility.
- It is the patient's right to have an advance directive; however, if a patient has a procedure done in this center, they must understand that the center does not honor advance directives and signs a consent form prior to their procedure regarding their understanding.

TO OUR PATIENTS

The medical director & nurses of this facility want to be certain that the medical care you receive is the highest quality. Please let us know of any complaints or grievances you have. If you are still dissatisfied, feel free to contact the following agencies:

Ohio Department of Health Hotline: 800-669-3534

Centers for Medicare & Medicaid Services website: http://www.cms.hhs.gov/center/ombudsman.asp or call: 1-800-633-4227