Digestive Health Center of Michigan
Patient Demographic/Consent to Treat

Last Name:	First Name:	Middle Ini:	DOB:
Address:			
City:	State:	Zip:	Home Phone:
Cell Phone:		SSN:	
Marital Status:	Sex:	Referring Doctor:	
Race: ☐ African Amer ☐ Asian ☐ White ☐ Pacific Islander ☐ Other		Ethnicity: ☐ Hispanic ☐ NonHispanic	
Emergency Contact:		Contact Number:	

Primary Insurance:	
Contract Number:	Group:
Subscriber's Name:	Subscriber's DOB:

Secondary Insurance:	
Contract Number:	Group:
Subscriber's Name:	Subscriber's DOB:

Pharmacy Name:	Pharmacy Phone:
City/ Cross Streets:	

Consent to treat- I authorize and consent to the treatment deemed necessary by the physician for myself or my child, which may include assessment of health status/history, first aid, necessary minor procedures, physical examination, health education, referral and follow-up.

Assignment of Benefits- I authorize payment of benefits to Digestive Health Center of Michigan for the services rendered. I understand that to the extent permitted by law, I am responsible for any costs not covered under my insurance plan.

Release of Information for Payment- I authorize the release of any medical or financial information, including any information related to AIDS, AIDS Related Complex (ARC) or HIV and any information regarding substance abuse treatment protected by 42 Code of Federal Regulation (CFR), part 2, and any mental health treatment, to any third party responsible for paying all or part of my (or my child's) medical bill. I understand that this authorization to release information may be revoked at any time and is only for the purpose of obtaining payment.

No Guarantee of Results of Care and Center's Termination Rights- I agree no one has promised or guaranteed any results of my or my child's medical care. I agree that nothing in this form prevents the medical center and it's staff from terminating my or my child's care if I am give reasonable notice and a chance to obtain medical services elsewhere.

Consent to HIV Testing- I understand that if a person working at the hospital is exposed to blood or body fluids while providing me care, the hospital may test my HIV Status in accordance with Michigan Public Health Code 1988, Public Act 488.

Patient/Parent/Guardian Signature Date

Witness Signature Date

DIGESTIVE HEALTH CENTER OF MICHIGAN
DHCMI

Ronald P. Fogel, MD • Yakir Muszkat, MD

30795 23 Mile Road, Suite 206, Chesterfield Twp., MI 48047 • Tel: (586) 598-5731
Fax: (586) 948-1530 • www.dhcmi.com • rfogel@dhcmi.com • ymuszkat@dhcmi.com

Notice of Privacy Practices Acknowledgement With Opportunity to Agree or Object

I acknowledge:

A copy of the Digestive Health Center of MI Notice of Privacy Practice was made available to me at the place where I went for health care services.

A copy of the Notice of Privacy Practices was made available for me to keep.

I received the notice of Privacy Practices the first day I received health care services at Digestive Health Center of MI.

Name of Patient: Date:

Signature of Patient or Representative: _____

Optional: Opportunity to Agree or Object

It is our practice to leave messages at your home regarding appointment reminders, prescription refills, or referral testing arrangements. (note: actual test results are NOT left as message.)

_____ YES, Leave messages on my answering machine or with the person who answers the phone.
_____ NO, Do not leave messages at my home, I prefer to be called at _____or contacted by mail at this address: _____.

I understand that my test results are private and will not be released to anyone other than myself unless I authorize it. I request that the following person has my consent to get my results,

NAME_____ Relationship _____

I understand that the above instructions will be in force until I notify the office of any changes.
Patients Initials _____

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AUTHORIZATION TO RELEASE/REQUEST MEDICAL RECORDS INFORMATION

TO: RONALD FOGEL, M.D. OR YAKIR MUSZKAT, M.D.
30795 23 MILE ROAD., SUITE# 206
CHESTERFIELD TOWNSHIP, MI 48047

PHONE: 586-598-5731
FAX: 586-948-1530

I hereby authorize the above listed entity to ☐ RELEASE ☐ RECEIVE my protected health information

Patient Name: _____ **Date of Birth:** _____

Address (street, city, state, zip code) _____ **Telephone number:** _____

Requested Dates of Service: _____ **Purpose of request:** *To CoordinateMedicalTreatment*

The following information is being requested:

☐ Complete record	☐ Cardiac	☐ X-Ray Reports
☐ Physician/Office Notes	☐ Tests	☐ History/Physical
☐ Labs	☐ EGD/Colonoscopy	☐ Pathology Reports

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infrection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse unless indicated below.

☐ I do not authorize the release of records regarding HIV infection, AIDS related Complex, and/or serious communicable diseases.
☐ I do not authorize the release of records regarding drug/alcohol abuse.

Redisclosure: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Signature of Patient or Legal Representative/Date:	Witness Signature/Date:

If Signed by legal representative, relationship to patient: _____

DIGESTIVE HEALTH CENTER OF MICHIGAN

Name: **Date of Birth:** **Date:**

Referring Physician: **Primary Care Physician:**

REASON FOR VISIT:

- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Colon Cancer Screen
- ☐ Colon Polyp History
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn / Reflux
- ☐ Trouble swallowing
- ☐ Other: _____

_____

HISTORY OF PRESENT ILLNESS:

Date you first noticed the problem: _____

Have you ever had this type of problem before?: (Please circle) YES NO

What makes your problem better: _____

What makes your problem worse: _____

Does your problem interfere with regular activities? (Please Circle) YES NO

Are you experiencing pain associated with your problem? (Please Circle) YES NO

Location of pain? (Please Circle) UPPER ABDOMEN LOWER ABDOMEN CHEST

Describe your pain: (Please Circle) SHARP DULL CONSTANT INTERMITTENT

Intensity of pain (On a scale from 0-10, {0= No Pain, 10= Worst pain}) : _____

Bowel Habits: _____ per day/per week

Do you have?:

Normal Stools:	☐ Yes	☐ No	Hard Stools:	☐ Yes	☐ No
Blood in Stools:	☐ Yes	☐ No	Mucus in Stools	☐ Yes	☐ No
Black Stools:	☐ Yes	☐ No	Sense of Urgency	☐ Yes	☐ No
Diarrhea:	☐ Yes	☐ No	Thin Caliber:	☐ Yes	☐ No

REVIEW OF SYSTEMS: *(Please check the symptoms you currently have or have had in the past year.)*

General:
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Nervousness
- ☐ Numbness
- ☐ Fatigue

Pulmonary:
- ☐ Wheezing
- ☐ Shortness of breath

Eye, Ear, Nose, Throat:
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Snoring

Genitourinary:
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Painful urination

Cardiovascular:
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles

Gastrointestinal:
- ☐ Belching / Bloating
- ☐ Difficulty swallowing
- ☐ Excessive gas
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Weight Loss
- ☐ Yellow jaundice

ALLERGIES: *(Please list any allergies you have. If you don't have any, please write NONE.)*

_____

_____

FAMILY HISTORY:

Any family member with:

Colon Polyps ☐ Yes ☐ No

Colon Cancer ☐ Yes ☐ No

If yes to the above, please list relationship: _____

HOSPITALIZATIONS/SURGERIES:(*Please list illness and/or surgery with the approximate year)*

_____

_____

PAST MEDICAL HISTORY: *Please check any conditions you have or have had in the past.*

☐ AIDS	☐ Bronchitis	☐ Heart Failure	☐ Multiple sclerosis
☐ Alcoholism	☐ Bulimia	☐ Heart Murmur	☐ Pacemaker/ICD
☐ Anemia	☐ Cancer _____(type)	☐ Heart Surgery	☐ Pneumonia
☐ Anorexia	☐ Chemical Dependency	☐ High Cholesterol	☐ Rheumatic Fever
☐ Anxiety	☐ Depression	☐ HIV Positive	☐ Seizures
☐ Appendicitis	☐ Diabetes	☐ Hypertension	☐ Sleep apnea
☐ Artificial heart valve	☐ Emphysema/COPD	☐ Kidney Disease	☐ Stroke/TIA
☐ Asthma	☐ Endometriosis	☐ Kidney Stones	☐ Thyroid problems
☐ Bleeding disorders	☐ Fibromyalgia	☐ Lupus	☐ Tuberculosis
☐ Blood clots	☐ Heart Attack	☐ Migraines	

Other: _____

PREVIOUS GASTROINTESTINAL PROBLEMS:

☐ Achalsia	☐ Esophageal Stricture	☐ Liver Disease
☐ Barrett's Esophagus	☐ Gallstones / Gallbladder Problems	☐ Pancreatitis
☐ Colon Cancer	☐ Gastrointestinal Bleeding	☐ Peptic Ulcer Disease
☐ Colon Polyps	☐ GERD / Reflux	☐ Ulcerative Colitis
☐ Crohn's Disease	☐ Hemorrhoids	☐ Other _____
☐ Diverticulosis	☐ Irritable Bowel / Spastic Colon	_____

PREVIOUS GASTROINTESTINAL EXAMS:

☐ Barium Swallow	☐ CT Scan: _____	☐ Small Bowel Series	☐ Upper GI Series
☐ Capsule Endoscopy	☐ ERCP	☐ Ultrasound: _____	☐ Other: _____
☐ Colonoscopy	☐ MRI: _____	☐ Upper Endoscopy (EGD)	_____

PERSONAL SOCIAL HISTORY:

Do you currently smoke?	☐ Yes	☐ No	If yes, #_____ packs/day for _____ years
Have you ever smoked?	☐ Yes	☐ No	If yes, #_____ years quit
Do you currently use alcohol?	☐ Yes	☐ No	If yes, _____ oz/week, _____beers/week
Have you ever used alcohol?	☐ Yes	☐ No	If yes, #_____ years quit
Do you have daily caffeine intake?	☐ Yes	☐ No	If yes, what is the source and amount of intake? (i.e. coffee, soda, chocolate, tea, diet pills e tc.)_____

FOR WOMEN ONLY:

Are you post menopausal? ☐ Yes ☐ No

If no, when was your last menstrual period? _____

Are you Pregnant? ☐ Yes ☐ No

Are you Nursing? ☐ Yes ☐ No

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FINANCIAL POLICY

In the interest of maintaining a good doctor-patient relationship, it is our hope that you will review the policy so discussion of these issues early in the treatment process will prevent confusion or misunderstanding in the future. Please do not hesitate to discuss any issues about your account or to make payment arrangements with our office personnel.

INSURANCE: We will file claims for all professional services provided by Digestive health delivered in the office or at the hospital. It is with the understanding and consent of the patient that all benefits will be assigned to Digestive Health Center of Michigan; insurance carrier, deductibles, co-pays and non-covered services are the responsibility of the patient. Please note that your insurance company has the right to deny payment for procedures. In the event that the patient does not have any medical symptoms, the doctor may request an office visit prior to performing any procedure, screening or not, which he deems medically necessary.

If you have no insurance coverage or are unable to pay at the time services are rendered, we will work with you to make financial arrangements. We will request a payment for outpatient procedures prior to having the procedure performed.

RETURNED CHECKS: Your account will be charged a $20.00 fee for any returned check. In the future, you will be requested to bring cash to cover the retuned check and fee.

PATIENT STATEMENT: I have been informed of the financial policy of Digestive Health Center of Michigan and agree to its terms. I have been notified that my insurance company may deny payment for my initial office visit for the above stated reasons and I agree to be personally responsible for payment.

Signature_____ **Date:** _____

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We appreciate that the majority of our patients arrive for their appointments on time and when needing to cancel their appointments, do so well in advance of their appointment, so that we can see patients from our waiting list.

In recent years, however, we have seen a steady rise in the number of patients that have not been showing up for their appointments or not calling to cancel their appointments until just prior to their appointment. When this happens, an open slot that could have been filled by another patient in need of urgent evaluation is lost.

After much review we have determined that we have no choice but to charge patients for a late cancellation (less that 24 business hours notice) or those who fail to show up for their scheduled appointments ("No Shows").

We understand that there can be extenuating circumstances, beyond the control of the patient, so we have built into our policy both one free late cancellation or "No Show" per calendar year, as well as the option to request that the charge be waived in situations that were truly beyond the ability of the patient to call earlier or present for their appointment.

Our goal is to improve patient satisfaction by increasing our ability to help patients who are waiting for an urgent appointment.

POLICY: Digestive Health Center of Michigan will allow one "No Show" or "Late Cancellation" per calendar year at no charge. There will be a $25.00 charge for additional Late Cancellation (less than 24 business hours) or patient No Show during the same calendar year.

If you have State funded insurance, you will not be charged, but you can be dismissed from the practice due to the Late Cancellation/No show policy.