CENTER FOR DIGESTIVE WELLNESS PC
Elliot J. Feinberg, MD
Amin K. Soltani, MD
Vernu Visvalingam, MD
Center for Digestive Wellness
105 Erdman Way
Leominster, MA 01453
Phone: 978-537-7552
Fax: 978-537-7383

Please complete the attached new patient paperwork and return to us prior to your scheduled appointment. Please also send a copy of your ID and the front/back of your insurance card(s). You may send to us via fax, email (not secured), mail, or drop off at our office. Thank you!

Fax: 978-537-7383
Email: cfdw.patients@gmail.com
Address: 105 Erdman Way, Leominster, MA 01453

GASTROENTEROLOGY HEALTH QUESTIONNAIRE

NAME____**AGE**___ **Date of Birth**__________________ **Today's Date** __________

Referring Physician__________________________**Cardiologist (if applicable)**____________________________

Preferred Pharmacy Name & Location ____

REASON FOR VISIT ____

____

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____

ILLNESSES AND HOSPITAL ADMISSIONS

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICATIONS *(include over the counter medications)*

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN

DRUG ALLERGIES and reaction (rash, hives, don't know):____

____

LATEX ALLERGY (IF YES, PLEASE DESCRIBE):_______________________________

SOCIAL HISTORY

Alcohol_________Drinks per week Smoking__________packs per day________#yrs. When did you quit?_______________

Where do you/did you work? ____

FAMILY HISTORY

Indicate if ALIVE & WELL (A&W) or DECEASED (D), cancer/polyps or other illnesses and/or cause of death)

FATHER ____

MOTHER ____

BROTHERS_____(number) ____

SISTERS _______(number) ____

MOTHER'S RELATIVES____

FATHER'S RELATIVES____

 NAME:____

MEDICAL HISTORY (CHECK ALL OTHER SYMPTOMS YOU HAVE NOW)

GASTROINTESTINAL

_Blood in Stools
_Black tarry stools
_Vomiting blood
_Loss of appetite-recent
_Difficulty swallowing
_Indigestion/Heartburn
_Persistent Nausea or
_Vomiting
_Peptic Ulcers
_Abdominal pain-chronic
_Change in bowel habits
_Constipation
_Hemorrhoids
_ rectal abscess or fissure
_Diarrhea
_fecal incontinence
_more than 4 BMs/Day
_cramping with BMs
_"spastic colitis"
_Diverticulosis
_Gall Bladder trouble
_Hepatitis
_Jaundice recent or in past
_Colon Cancer

DIET

# of fruits/day _____
# of Vegetables/day_____
___ Bran cereal
___ Wheat bread?

DAIRY

___# glasses milk/day
___Do you eat cheese
___Do you eat Yogurt
___Do you eat ice cream

CONSTITUTIONAL

_Easy bruisability
_fever, sweats, or chills
_Dizzy spells
_Weight loss-recent
_Chronic fatigue
_ FIBROMYALGIA
_Other cancer__________

EYES

__ Eye infections-frequent
_Blurry Vision
_Failing vision
_yellow "whites" of eyes

EARS/NOSE/THROAT/MOUTH

_frequent sore throat
_dry mouth
_ sores in your mouth
_Ringing in ear
_Frequent nosebleeds

CARDIOVASCULAR

_Shortness of breath
_Chest pain
_Palpitations
_Irregular Pulse
_Fainting
_High blood pressure
_ARTIFICIAL VALVES
CLAUDICATION
_Swollen Ankles
_Leg pain when walking

PULMONARY

_Hoarseness-prolonged
_Short of breath at rest
_Bronchitis/Chronic cough

ALLERGY/IMMUNO

_Hayfever _Allergies
_Asthma/Wheezing
_Hives

GENITOURINARY

_Abnormally heavy menses
_Bloody urination
_Decreased force in urination
_Kidney stones

MUSCULOSKELETAL

_ OTC MEDS FOR PAIN?
_DO YOU TAKE ASPIRIN
_ARTIFICIAL JOINTS
_Arthritis/Rheumatism _Gout
_Back pain-recurrent
_Bone fracture/Joint injury

SKIN/ALLERGY

_Rashes
_yellowing of skin
_skin lesions that heal poorly
_Psoriasis _Eczema
-Itching

NEUROLOGICAL

_Convulsions/Seizures
_Stroke
_speech disturbance
_Numbness/Tingling
_Headaches-frequent

PSYCHIATRIC

_Sleeping-difficulty
_Nervousness _Depression
_Memory loss _Mental illness
_Moodiness _Phobias

ENDOCRINE

_DIABETES
_Thyroid Disease
_Recent hair loss

LYMPHATIC

_Anemia
_BLEEDING TENDENCY
_lymph node pain/enlargement
_TRANSFUSIONS

NAME:____

OFFICE USE ONLY

VS RR= P= BP= WT= Height= ASA= MP=

Cross out all that do not apply, or add comments

EYES: Conjunctiva are pink. PERRL. Sclera are anicteric.

ENT: External inspection WNL. MMM without lesions. Lips, teeth, and gums WNL.

CHEST: Respiratory effort WNL. Clear to auscultation.

HEART: NL S1/S2, RRR.

ABDOMEN: NL BS. NT/ND with no masses. No HSM.

Normal tympany in all quadrants.

EXT: Pedal pulses are intact. There is no peripheral edema.

RECTAL: NL tone, OB negative brown stool.

SKIN: No jaundice. Palpation is normal. No spider angiomata, no palmar erythema.

LABS -

IMPRESSION -

PLAN –

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105 Erdman Way
Leominster, MA 01453

PATIENT FINANCIAL & REFERRAL RESPONSIBILITY

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. Our billing department will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

Many insurance companies have additional requirements or stipulations that may affect coverage, such as obtaining a referral from your primary care provider prior to the appointment with the specialist. *If you visit a specialist without a referral, depending on your plan type, you may be responsible for payment for all services rendered, or for paying a deductible and co-payment or coinsurance, as determined by your insurance plan.* Those payments will be due at the time of service. The referral is not a guarantee of payment.

You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

ACKNOWLEDGEMENT:
I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

Patient Name (Print): x____________________________________

Date of Birth: x____

Patient Signature: x______________________________________

Date: x____

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Patient Responsibility if No Insurance Referral:

- Dr. Elliot Feinberg – NPI # 1962442491
- Dr. Amin Soltani – NPI # 1912361643
- Dr. Vernu Visvalingam – NPI # 1396700274

Dear Patient:

Not all insurance companies require a referral for office visits or procedures but many do; Please contact your primary care physician's office to check if an insurance referral is required. Obtaining the referral is your responsibility as the patient. If it is not available by the time of your service you typically have 14 days from the time of service to provide us with the referral. By signing here, you agree that if the referral is required and not provided, you accept full financial responsibility.

Patient Name: ______________________________

Patient Date of Birth: ______________________________

Signature **X**______________________________

Today's Date: **X**______________________________

Notice of Privacy Practices

Center for Digestive Wellness, PC - This Notice describes how medical information about you may be used/disclosed, and how you can obtain access to this information. Please review it carefully

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically, and if so, is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example - Nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping you with your care.
Payment: We will use and disclose your health information for payment purposes. For example - We may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services, and to assess the care and outcomes of your case and others like it.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as report to gunshot wounds, suspected abuse/neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena, discovery request, or court order.
Law Enforcement Purposes: We may disclose information needed or requested by law enforcement officials, or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral director, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions, or for national security purposes.
Worker's Compensation: We may release information about you for worker's compensation or similar programs providing benefits for work related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders, or for billing or collections, and may leave messages on your answering machine, voice mail, or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes, or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
-You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request, and when the uses or discloses are not required by law.
- You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
-In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
-You have the right to request that we amend your information.
-You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations, and except for other exceptions.
-You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:
Office Manager: (978) 537-7552

I ______________________________,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.
Signed:
____
Date:
____

If not signed, reason why acknowledgement was not obtained:
____
Staff witness seeking acknowledgement:
____
*Date:*____________________

Effective Date: 6/22/2017

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Authorization to Share Medical Information

Including, but not limited to, diagnoses, testing, prognosis, treatment, and billing.

Name: ______________________________ DOB: ________________

Is there anyone with whom you give us permission to share your medical information? If so, please provide:

Name of Designated Person: ______________________________

Phone #: ______________________________

Relationship to Patient: ______________________________

Name of Designated Person: ______________________________

Phone #: ______________________________

Relationship to Patient: ______________________________

Do you give permission for us to either discuss or leave a message regarding specific information pertaining to an appointment or a medical condition on your:

Home Phone: Circle One: Yes No Phone #: ______________________________

Cell Phone: Circle One: Yes No Phone #: ______________________________

I understand that I have the right to revoke this authorization at any time.

I understand that this authorization will not expire, unless otherwise revoked.

I have read and understand the above statements and authorize the disclosure of the information requested above.

Signature: ______________________________ Date: ________________