☐ Alan F. Cutler, M.D., F.A.C.G., F.A.C.P., A.G.A.F.
☐ Janice M. Fields, M.D., F.A.C.G., F.A.C.P.
☐ Roberto M. Gamarra, M.D., F.A.C.G., F.A.C.P.
☐ Phillip A. Goldmeier, M.D., F.A.C.G., F.A.C.P.
☐ Randall S. Jacobs, M.D., F.A.C.G., F.A.C.P.
☐ Jay R. Levinson, M.D., F.A.C.G.
☐ Michael H. Piper, M.D., F.A.C.G., F.A.C.P.
☐ Michael R. Raphael, D.O., F.A.C.O.I.
☐ Bradley J. Warren, D.O., F.A.C.G., F.A.C.O.I.
☐ Edward A. Yousif, M.D., F.A.C.G., F.A.C.P.
☐ Sonia Qatsha, PA-C, RD
☐ Tara Karmo, PA-C
☐ Rachelle Aldridge, PA-C

Board Certified in Gastroenterology

www.digesthealth.com

DHA DIGESTIVE HEALTH ASSOCIATES PLC

☐ 30055 Northwestern Hwy. #250, Farmington Hills, MI 48334 • 248.985.5000 • 248.985.5500 fax
☐ 11900 E. 12 Mile Road #307, Warren, MI 48093 • 586.573.8380 • 586.573.8979 fax
☐ 26850 Providence Parkway #510, Novi, MI 48374 • 248.662.4300 • 248.662.4301 fax
☐ 16001 West 9 Mile Road, 3rd Floor, Southfield, MI 48075 • 248.985.5000 • 248.985.5500 fax
☐ 205 W. Grand River #200, Brighton, MI 48116 • 248.662.4300 • 248.662.4301 fax
☐ 12660 10 Mile Road • South Lyon, MI 48178 • 248.985.5000 • 248.985.5500 fax

(see map page for directions on reverse side)

Appointment: _____

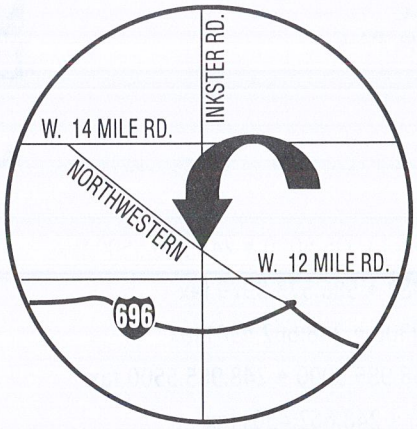
Thank you for choosing Digestive Health Associates. To assist our doctors and our medical staff, you will find enclosed a new Patient Packet. Please take your time to review and prepare this packet of information for your appointment with us.

A FEE APPLIES IF APPOINTMENTS ARE NOT CANCELLED WITHIN 24 HOURS

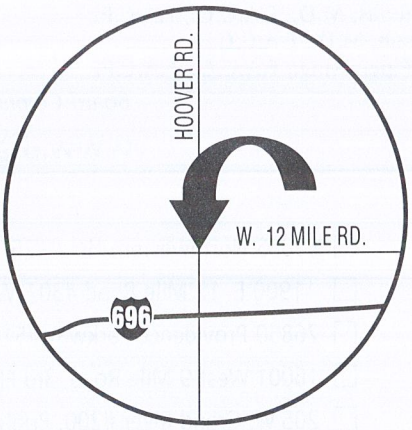
- Please arrive at our office 15 minutes prior to your scheduled time of appointment, as our registration personnel will need to process information at the time you arrive.
- Please contact your primary care physician or family physician and obtain any laboratory results (blood work), radiology reports (x-rays), so that our physicians will have important information for immediate review. It is best to bring them with you on the day of your visit or you may have the doctor's office fax us prior to your appointment date.
- If your insurance requires you to have a referral/authorization to visit us, please arrange this with your primary care physician's office to obtain this. **You will need to bring a copy of this referral to the office.** If you do not have a referral we will need to reschedule your appointment until one is obtained. Please verify the date of service on the referral is the same date as your scheduled appointment. It is also helpful to verify the doctor's name that you are scheduled to see is the same doctor's name on the referral/authorization. Not sure if your referral is at our office? Call us 24 hours prior to your appointment to verify.
- Also, you will be asked for a picture identification (driver's license), a copy of insurance card(s) and any payments due for past due balances, current copays/deductibles. Payment is due at the time of service.
- Last but just as important, please bring in or have a list of all current medications you are taking.

Our doctors and staff look forward to meeting and assisting you on your appointment with us. If you have any questions or need further assistance please contact our offices.

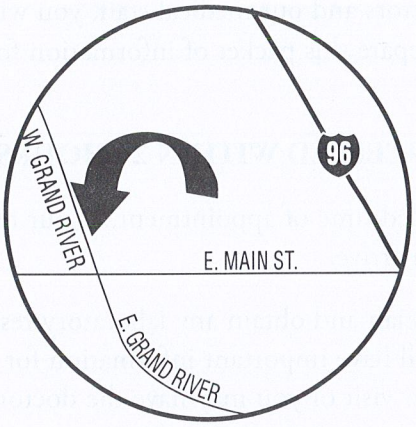
Digestive Health Associates PLC



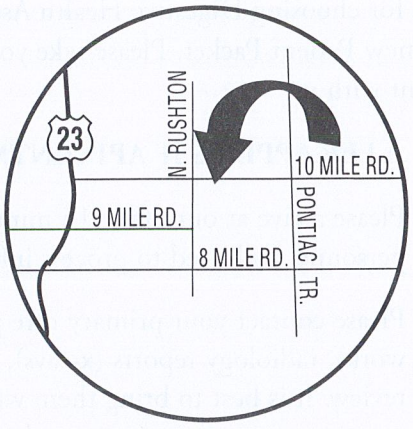
30055 Northwestern Hwy. #250
Farmington Hills, MI 48334
248.985.5000
inside Providence Medical Building
at the southwest corner of
Inkster & Northwestern
park at west entrance



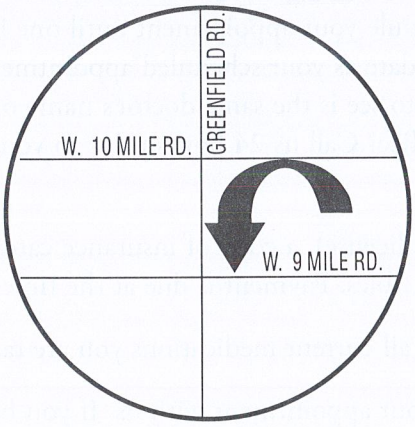
11900 E. 12 Mile Road #307
Warren, MI 48093
586.573.8380
next to St. John Macomb Hospital
at the southeast corner of
12 Mile & Hoover



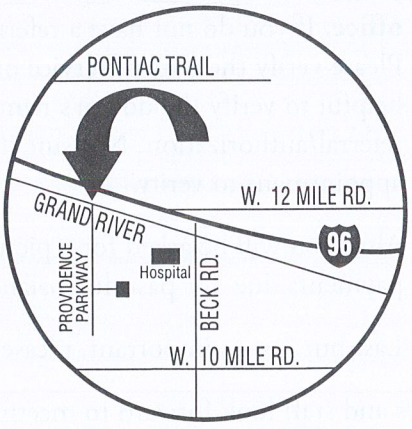
205 W. Grand River #200
Brighton, MI 48116
248.662.4300



12660 10 Mile Road
South Lyon, MI 48178
248.985.5000



16001 West 9 Mile Road, 3rd Floor
Southfield, MI 48075
248.985.5000
Just west of Greenfield
at Providence Drive



26850 Providence Parkway #510
Novi, MI 48374
248.662.4300
Located behind the hospital
on Providence Parkway

N
W E
S

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act (HIPAA, "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist you with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, you may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or discuss your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- Appointment: Reminders and Treatment Alternatives: We may contact you to provide appointment reminders or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Communications with individuals involved in Your Care: Unless you tell us otherwise, we may share your PHI with friends, family members or others you have identified or who are involved in your care.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service o item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Alan Cutler, M.D.
Phone number: 248-985-5000
Fax number: 248-538-3936

Office for Civil Right
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Hotline: 1-8800-368-1019

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on September 23, 2013.

Digestive Health Associates PLC

New Patient & Updated Patient Registration

TODAY'S DATE: _____

NAME:	SEX M F	DATE OF BIRTH:
SSN:		CURRENT AGE:
STREET ADDRESS:	CITY, STATE & ZIP:	
PHONE # - HOME: ( )	WORK: ( )	CELL PHONE #: - ( )
CAN PERSONAL MESSAGES REGARDING TEST RESULTS, APPOINTMENT TIMES, ETC. BE LEFT AT: HOME Y or N	WORK Y or N	CELL PHONE Y or N
REFERRED BY:	PHONE #: ( )	
MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED		
EMPLOYER:	PHONE #: ( )	
IF UNDER 18, PARENT/GUARDIAN:	NATURE OF ILLNESS/COMPLAINT:	
SPOUSE'S NAME:	SPOUSE'S DATE OF BIRTH:	
SPOUSE'S SOCIAL SECURITY NO. (For Billing Purposes)		
SPOUSE'S EMPLOYER:	PHONE #: ( )	
EMERGENCY CONTACT:	PHONE #: ( )	

If your insurance plan requires prior authorization, it must be obtained prior to your appointment.
Do you have the authorization today? ☐ Yes ☐ No If no, please see front desk personnel.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr.'s Alan Cutler, Janice Fields, Roberto Gamarra, Phillip Goldmeier, Randall Jacobs, Jay Levinson, Luis Maas, Michael Piper, Michael Raphael, Bradley Warren and Edward Yousif, doing business as Digestive Health Associates, PLC, for services rendered by him/her in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr.'s Alan Cutler, Janice Fields, Roberto Gamarra, Phillip Goldmeier, Randall Jacobs, Jay Levinson, Luis Maas, Michael Piper, Michael Raphael, Bradley Warren and Edward Yousif, doing business as Digestive Health Associates, PLC, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT NAME (please print) _____ DATE _____

PARENT/GUARDIAN (please print) _____

SIGNATURE: _____

DIGESTIVE HEALTH ASSOCIATES PLC

DATE: _____

PATIENT NAME: _____

MALE / FEMALE

AGE: _____ OCCUPATION: _____ FAMILY DOCTOR: _____

FAMILY DR'S ADDRESS: _____ PHONE: _____

OTHER DRS. YOU SEE: _____

CURRENT AND PAST MEDICAL PROBLEMS (Ex.: High blood pressure, diabetes, etc.)

ILLNESS: _____

PAST SURGICAL HISTORY

OPERATION	YEAR	REASON

OTHER HOSPITALIZATIONS

NAME OF HOSPITAL	YEAR	REASON

FOREIGN TRAVEL

PLACE: _____ YEAR: _____

_____ YEAR: _____

ALLERGIES TO MEDICATION

NAME: _____ REACTION: _____

_____ _____

PLEASE LIST PRESENT MEDICATIONS

NAME: _____ DOSAGE: _____

_____ _____

_____ _____

_____ _____

_____ _____

DO YOU USE ASPIRIN OR ARTHRITIS MEDICATIONS? _____

SOCIAL HISTORY

HABITS: Smoking (cigarettes, pipe, cigars) HOW MUCH? _____

Alcohol (wine, beer, liquor) HOW MUCH? _____

PLEASE COMPLETE REVERSE SIDE ▶

DIET

(Please indicate how much is used)

COFFEE: _____ CHOCOLATE: _____ FIBER: _____

TEA: _____ MINTS/GUM: _____ POP: _____

MILK OR DAIRY PRODUCTS: _____

FOOD INTOLERANCE: _____

FAMILY HISTORY

	LIVING OR DECEASED	AGE (now or at death)	ILLNESS OR CAUSE OF DEATH
FATHER:			
MOTHER:			
	(list individually)		
SISTERS:			
BROTHERS:			
CHILDREN:			

ANY FAMILY MEMBERS KNOWN TO HAVE COLON CANCER OR POLYPS? ☐ YES ☐ NO

IF YES, RELATIONSHIP TO PATIENT: _____

REVIEW OF SYSTEMS

HAVE YOU RECENTLY HAD ANY:

General:	Y	N
Trouble sleeping	☐	☐
Change in weight	☐	☐
Loss of energy	☐	☐
Fevers/Chills	☐	☐
Night sweats	☐	☐
Skin:		
Rashes	☐	☐
Changes in skin color	☐	☐
Unhealed sores	☐	☐
Blood:		
Unusual bleeding	☐	☐
Easy bruising	☐	☐
Anemia	☐	☐
Enlarged glands	☐	☐
Endocrine:		
Heat/Cold intolerance	☐	☐
Hair growth/loss	☐	☐
Increased thirst	☐	☐
Increased hunger	☐	☐

Eyes/Ears/Mouth:	Y	N
Vision trouble	☐	☐
Double vision	☐	☐
Eye pain	☐	☐
Hearing trouble	☐	☐
Ringing in ears	☐	☐
Dizziness	☐	☐
Dental problems	☐	☐
Difficulty swallowing	☐	☐
Mouth sores	☐	☐
Hoarseness	☐	☐
Lungs:		
Nose bleeds	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Asthma	☐	☐
Cold	☐	☐

Cardiac:	Y	N
Heart problems	☐	☐
Chest pain	☐	☐
Heart murmurs	☐	☐
Heart attacks	☐	☐
Fainting	☐	☐
Difficulty lying down	☐	☐
Gastrointestinal:		
Abdominal pain	☐	☐
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Urinary:		
Burning in urine	☐	☐
Blood in urine	☐	☐
Increased urine	☐	☐
Flank pain	☐	☐
Trouble in stop/start	☐	☐

Muscles/Skeleton:	Y	N
Joint pain	☐	☐
Morning stiffness	☐	☐
Back problems	☐	☐
Neurologic:		
Blankouts	☐	☐
Seizures	☐	☐
Frequent headaches	☐	☐
Muscle weakness	☐	☐
Trouble talking	☐	☐
Balance problems	☐	☐
Memory changes	☐	☐
Emotion:		
Mood swings	☐	☐
Crying spells	☐	☐
Depression	☐	☐
Psychiatric treatment	☐	☐

Review w/Patient: _____ (Initials) _____ (Date) Updated: _____ (Initials) _____ (Date)