Drossman Gastroenterology, PLLC

Douglas A Drossman, M.D.
5826 Fayetteville Rd., Suite 201, Durham, NC 27713
Phone 919-246-5611 • Fax 919-914-0942

NEW PATIENT REFERRAL/CONSULTATION

Thank you for your interest in our clinic! To schedule an appointment with one of our providers, you or your doctor must first complete this detailed referral form and return it to us. Appointments cannot be made until we receive all of the following information:

- ☐ **Patient Demographic Information** (Fill out below form)
- ☐ **Pertinent Medical Records** including recent clinic visits, labs, GI procedures, imaging reports and discharge summaries (release form attached if needed)
- ☐ **Financial Policy Form** (attached)
- ☐ **Letter of referral from a physician**. This letter should summarize the patient's symptom(s), history, treatments and medical tests, as well as the specific questions the referring physician wishes to be addressed in our clinic. REFERRALS WITHOUT A LETTER OR THE DETAILED CONSULTATION FORM FROM A PHYSICIAN WILL NOT BE PROCESSED.

Please return this form and any other materials to our clinic by mail or fax. Once your completed referral is received, it will be processed usually within 7 business days. You will then be contacted by our scheduling team about the date and time of your appointment.

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME: _____

PRIMARY PHONE: _____ □ home □ cell □ work

ALTERNATE PHONE: _____ □ home □ cell □ work

STREET ADDRESS: _____

CITY, STATE, ZIP _____

SEX: □ MALE □ FEMALE DATE OF BIRTH: _____

EMAIL ADDRESS: _____

CHECK ALL THAT APPLY:

- ☐ Atypical Chest Pain
- ☐ Functional Dyspepsia
- ☐ Dysphagia
- ☐ Reflux
- ☐ Swallowing Disorder
- ☐ Cyclic Vomiting
- ☐ Vomiting
- ☐ Nausea
- ☐ Crohn's Disease
- ☐ IBD
- ☐ Ulcerative Colitis
- ☐ Pelvic Pain
- ☐ Rectal Pain
- ☐ Chronic Abdominal Pain
- ☐ IBS-Diarrhea
- ☐ IBS- Constipation
- ☐ IBS- Mixed
- ☐ Chronic Constipation
- ☐ Chronic Diarrhea
- ☐ Pelvic Floor Dysfunction
- ☐ Fecal Incontinence
- ☐ GI Malignancies
- ☐ Motility Problem
- ☐ Currently on narcotic medication
- ☐ Other Functional GI Disorders
- ☐ Other: _____

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SPECIFIC QUESTION(S) TO BE ADDRESSED: _____

_____

_____

_____

_____

REFERRING PHYSICIAN CONTACT INFORMATION

PHYSICIAN'S NAME: _____

PRACTICE NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP _____

PHONE: _____

FAX: _____

EMAIL ADDRESS: _____

☐ **Check here if you are also the primary care physician**

PRIMARY CARE PHYSICIAN INFORMATION

PHYSICIAN'S NAME: _____

PRACTICE NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP _____

PHONE: _____

FAX: _____

EMAIL ADDRESS: _____

Please mail or fax Referral Form, along with letter of reference from physician, medical records, and financial disclosure form to:

Drossman Gastroenterology, PLLC
Attn: New Referrals
5826 Fayetteville Rd., Suite 201
Durham, NC 27713
Fax: (919) 914-0942

Drossman Gastroenterology

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Medical Information Release Form

Patient:	Date of Birth:	Patient Phone Number:

I, _____, the patient/guardian/healthcare power of attorney,

authorize **Drossman Gastroenterology to** **(circle one)**

___ **receive** medical and other information from:

___ **release** medical and other information to:

Individual Name or Practice (required):

_____

Phone (required): _____Fax: _____

Specify Email or Street Address*: _____

City (required): _____ State: _____ **Zip Code**: _____

***There is a charge for printed records**. *If records are being requested to be sent to a lawyer, insurance or workers compensation company, please have them contact us with a written request; otherwise the patient will be charged per North Carolina General Statues 90-411: printed Records Medical Record charges inclusive of searching, handling, copying, and mailing costs are: $.75/page for first 25 pages $.50/page for pages 26-100 $.25/page for pages over 100 Minimum fee of $10.00 permitted*

TREATMENT DATES TO BE DISCLOSED: ☐Entire ☐Year to Date ☐Other_____

PURPOSE OF THE DISCLOSURE: ☐Insurance ☐Legal ☐Continuing Care ☐Personal ☐Other (specify)

_____

SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

☐History and Physicals ☐Progress Notes ☐Hospital ☐Correspondence

☐Labs and X-rays ☐Insurance ☐Miscellaneous ☐All

SPECIFIC INFORMATION TO **NOT** BE DISCLOSED: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that one the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Drossman Gastroenterology. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize Drossman Gastroenterology to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.

I hereby release Drossman Gastroenterology from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.

_____ _____

PATIENT'S SIGNATURE **DATE**

_____ _____

PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN **DATE**

_____ _____

WITNESS **DATE**

Douglas A. Drossman, MD
Founder and Clinical Director
doug@drossmancenter.com
919.246.5611

Clinic Location:
5826 Fayetteville Rd.
Suite 201
Durham, NC 27713

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Financial Policy

As a result of our sincere desire to base all medical decisions on what is best for the patient, not what is best for the insurance company, we are not contracted with any insurance carriers.

1. All charges must be paid at the time of service and our treatment fees are the same for all patients, regardless of whether they have insurance coverage.

2. The contract with your insurance company to pay for a portion of your medical care is between you and your insurance company. By eliminating costs associated with billing, coding diagnoses and procedures, referrals, authorizations, payment delays, EOB reviews, claim denials, re-submissions, collection risks, and other managed care costs, we can provide patients a fair price for services without the administrative hassles and bureaucracy.

3. It is your responsibility to obtain all referrals/authorizations required by your insurance plan and to file your claim with your referral/authorization.

4. You will be given a completed claim form (and a duplicate copy for your records) with all the codes necessary for you to file a claim with your insurance carrier. We recommend you contact your insurance carrier and request instructions for filing your claims.

5. Our office does not fill out "forms" from insurance companies. A copy of the patient's medical records will be forwarded to the insurance company when a signed authorization to release medical records is received. Their medical review professionals can extract the information required from these records.

6. Medicare: Dr. Drossman has chosen to "Opt Out" of Medicare. All patients who are on Medicare, or are eligible for Medicare, must sign the federally mandated "Private Contract" in order to receive services at our clinic. All services must be paid at the time of service. Neither Dr. Drossman nor the patient may file a claim to Medicare for reimbursement.

7. Medicaid: We are not accepting any Medicaid patients. We will only accept "Private Pay" patients. We will not file any claims to Medicaid for reimbursement of your medical services now or at any time in the future.

8. Champus/Tricare: We are not an active Champus/Tricare/Tricare for Life provider. We will not accept Champus/Tricare/Tricare for Life insurance, we will not file any claims to Champus/Tricare/Tricare for Life and we will not accept the Champus/Tricare/Tricare for Life fee schedule for reimbursement of our services.

9. We will not file any claims for insurance benefits/reimbursement and we will not provide any discounts/write-offs for insurance or workers compensation plans.

By signing this document, you are agreeing to pay for our services in full and forego any insurance benefits/discounts.

I have read, understand and agree to the terms and conditions listed above.

_____ _____

Signature of Patient or Parent if Patient is a Minor Date