Colon and Rectal Surgery Inc.
The Colonoscopy Center Inc.

REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician: Referring Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Dr. ❑Mr. ❑ Mrs. ❑ Miss ❑ Ms.			Marital status ❑ Single ❑Married ❑ Divorced ❑ Separated ❑ Widowed
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		Birth date: / /	Age:		Sex: ❑ M ❑ F
Street address:		Social Security no.:	Home Phone : ( )			
City:	State	Zip	Cell Phone: ( )			
Race: ❑ Hispanic / Latino ❑ Non-Hispanic / Latino ❑ Unknown / Not Reported	Ethnicity:	Preferred Language:	Employer:			

INSURANCE INFORMATION

Primary Insurance:	(Please give your insurance card to the receptionist.)			
Subscriber's Name:	Birth date:	Employer:	Home phone no.: ( )	
Insurance Company Name:		ID Number:		Group Number:
Relationship to Subscriber	❑ Self ❑ Spouse ❑ Child ❑ Other			
Secondary Insurance:	(Please give your insurance card to the receptionist.)			
Subscriber's Name:	Birth date:	Employer:		Home phone no.: ( )
Insurance Company Name:		ID Number:	Group Number:	
Relationship to Subscriber	❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Colon and Rectal Surgery Inc or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Colon and Rectal Surgery Inc.
The Colonoscopy Center Inc.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS AUTHORIZATION

Name of Patient: _____

Date of Birth: _____

Financial Responsibility:

I have requested medical services from Colon and Rectal Surgery Inc. ("CRS")/The Colonoscopy Center Inc ("CCI") on behalf of myself and/or my dependents. I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the authorized treatment. I understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

Assignment of Benefits

I hereby assign all medical and surgical benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to CRS/CCI for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I will fully cooperate with CRS/CCI to obtain payment from my insurance carrier(s), if any. I understand that I am fully responsible for any amount not covered by my insurance.

I understand that in order to determine whether I need pre-certification or pre-authorization for my services, I can contact my insurance company at the number located on my insurance card. I understand that if I am still unsure, I can ask the clinic to contact my insurance company on my behalf. I acknowledge that it is my responsibility to make sure that any pre-certification or pre-authorization requirements of my insurance company are satisfied prior to my visit.

I understand that depending on my visit, I may receive a separate bill from both CRS for my physician's services and CCI for my use of the facility. I may also receive a separate bill from a third party for labs or other third party providers. I understand that all CRS/CCI billing is performed in accordance with Medicare's or my insurance company's guidelines.

I understand that CRS/CCI accepts Medicare and most insurance plans; however, CRS/CCI is not a preferred provider on all plans and some insurance plans will not pay charges from The Colonoscopy Center Inc. I acknowledge that I am responsible for all charges not paid by my insurance plan. I understand that it is my responsibility to make sure that CRS/CCI has accurate information about my insurance coverage. At each visit, I will verify that the insurance on file for me is accurate.

Authorization to Release Information

I hereby authorize CRS/CCI to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This authorization shall remain in effect until revoked by me in writing.

A photocopy or electronic version of this authorization shall be as valid as the original.

Patient/Responsible Party Signatures: _____ Date: _____

Witness: _____

Colon and Rectal Surgery Inc.
The Colonoscopy Center Inc.

ELECTION AND CONSENT FOR PHYSICIAN-PATIENT COMMUNICATION

Colon and Rectal Surgery Inc. ("CRS")/The Colonoscopy Center Inc ("CCI") may disclose your relevant medical information to family members or others you designate who are involved in your care or payment for your care. To better understand your wishes and which family members and friends/others are involved in your care or payment for your care, we ask each patient to designate in writing those individuals who may receive information relating to your medical care or payment at CRS/CCI. By filling out the information below, we will be better able to serve you.

CRS/CCI may leave voicemail messages on the following information at the following numbers:

1. Home: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment
2. Cell: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment
3. Work: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment

CRS/CCI may leave the following information with the following people:

1. Spouse/Partner: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment
2. Son/Daughter: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment
3. Other: _____ ❑ Appointment ❑ Test Results ❑ Instructions ❑ Payment

Patient portal registration:

Colon and Rectal Surgery Inc. will use the NextGen Patient Portal to allow you to connect with your doctor through a convenience, safe and secure environment.

1. Registration Email: _____

I understand that CRS/CCI does not and cannot guarantee the confidentiality of any voicemail messages or email communication and will not be liable for improper disclosure of confidential information and/or breaches in information caused by me or a third party.

I hereby voluntarily request and consent to communication with my physician and/or office personnel via the above designated communication methods.

_____ _____ _____
Signature of Patient Printed Name Date

If patient is a minor, has a legal guardian, or a power of attorney exists:

_____ _____ _____
Signature of Responsible Party Printed Name Date

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Date of Birth:
Name:

Patient History Form

Reason for Visit:

Please describe your reason for today's visit:_____

What are you hoping to get out of today's visit?_____

How long has this been going on?_____

Does anything make your condition worse: ☐ No ☐ Yes Please describe_____

Does anything particular help with your condition: ☐ No ☐ Yes Please describe_____

Medications - Please document any medications you are currently taking.
☐ Please check if NO current medications

	Name	***Dose (Strength)***	***How Many?***	***How Often?***
Example:	*Aspirin*	*81mg*	*1 tablet*	*Daily*
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Do you take aspirin? ☐ No ☐ Yes **If yes, please enter above.**

Do you take other blood thinners? ☐ No ☐ Yes **If yes, please enter above.**

Have you taken steroids (i.e. prednisone or cortisone) within the last 6 months? ☐ No ☐ Yes

If yes, what kind of steroid? Name: _____ Dose: _____ For how long? _____

When was the last dose? _____

Do you have any medication allergies? ☐ No ☐ Yes If yes, please list below:

1. _____ **What type of reaction?** _____

2. _____ **What type of reaction?** _____

Are you allergic to latex? ☐ No ☐ Yes **What type of reaction?** _____

Have you ever had the Pneumonia Vaccine? ☐ No ☐ Yes **Date:**_____

Have you had your flu shot this season (Oct.-Mar.)? ☐ No ☐ Yes **Date:**_____

Review of Systems – Please check any symptoms you are currently experiencing.

Constitutional

Chills	☐ No	☐ Yes
Fever	☐ No	☐ Yes
General discomfort (Malaise)	☐ No	☐ Yes
Unplanned weight loss (10+ pounds)	☐ No	☐ Yes
Weight gain (10+ pounds)	☐ No	☐ Yes

Hearing/Eyes/Vision (HEENT)

Double vision	☐ No	☐ Yes
Ear infections	☐ No	☐ Yes
Eye pain	☐ No	☐ Yes
Nasal congestion	☐ No	☐ Yes
Sinus infection	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes

Respiratory

Asthma	☐ No	☐ Yes
Difficult or labored breathing (dyspnea)	☐ No	☐ Yes
Frequent cough	☐ No	☐ Yes
Pleuritic pain	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

Cardiovascular

Chest pain	☐ No	☐ Yes
Swelling in extremities	☐ No	☐ Yes
Irregular heartbeat (palpitations)	☐ No	☐ Yes

Gastrointestinal

Abdominal pain	☐ No	☐ Yes
Change in stools	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Trouble swallowing (dysphagia)	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Vomiting of blood (Hematemesis)	☐ No	☐ Yes
Blood in stools (Hematochezia)	☐ No	☐ Yes
Loss of appetite	☐ No	☐ Yes
Black tarry stools	☐ No	☐ Yes
Nausea	☐ No	☐ Yes
Reflux	☐ No	☐ Yes
Vomiting	☐ No	☐ Yes
Accidental bowel leakage (ABL)	☐ No	☐ Yes

Genitourinary

Pain with urination (dysuria)	☐ No	☐ Yes
Blood in Urine (hematuria)	☐ No	☐ Yes
Urinary Frequency	☐ No	☐ Yes
Urinary incontinence (leakage of urine)	☐ No	☐ Yes
Urinary retention	☐ No	☐ Yes

Reproductive (Females Only)

Breast lumps	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Vaginal discharge	☐ No	☐ Yes
Painful intercourse (dyspareunia)	☐ No	☐ Yes

Reproductive (Males Only)

Penile Discharge	☐ No	☐ Yes
Sexual dysfunction	☐ No	☐ Yes

Metabolic/Endocrine

Cold intolerance	☐ No	☐ Yes
Excessive thirst	☐ No	☐ Yes
Heat intolerance	☐ No	☐ Yes
Gynecomastia (males)	☐ No	☐ Yes

Neurological

Dizziness	☐ No	☐ Yes
Headache	☐ No	☐ Yes
Extremity numbness / Tingling	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Vertigo	☐ No	☐ Yes
Seizures	☐ No	☐ Yes

Psychiatric (Mental Health)

Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Increased stress	☐ No	☐ Yes

Integumentary (Skin)

Hives	☐ No	☐ Yes
Itching (pruritus)	☐ No	☐ Yes
Rash	☐ No	☐ Yes

Musculoskeletal

Back pain	☐ No	☐ Yes
Muscle pain (Myalgia)	☐ No	☐ Yes
Joint pain	☐ No	☐ Yes

Hematologic/Lymphatic (Bleeding)

Easy bleeding	☐ No	☐ Yes
Easy bruising	☐ No	☐ Yes
Lymphadenopathy	☐ No	☐ Yes

Immunologic

Food allergies	☐ No	☐ Yes
Seasonal allergies	☐ No	☐ Yes

Problem List – Please check the appropriate boxes if you have been diagnosed and/or are being treated for any of the following conditions.

N/A Nothing Applicable ☐

Blood Problems
- ☐ Anemia *D64.9*
- ☐ Blood Clots (DVT/Embolism) *Z86.718*
- ☐ Bleeding disorder *D69.9*
- ☐ Clotting disorder *D68.9*

Cardiac Vascular
- ☐ Angina (chest pain) *I20.9*
- ☐ Arrhythmia (heart rhythm problems) *I49.9*
- ☐ Atrial fibrillation *I48.91*
- ☐ Heart failure *I50.9*
- ☐ Hyperlipidemia (high cholesterol) *E78.5*
- ☐ Hypertension (high blood pressure) *I10*
- ☐ Malignant hyperthermia *T88.3*
- ☐ Past heart attack *I25.2*
- ☐ Peripheral vascular disease: (Blood vessel problems in legs) *I73.9*

Cancer
- ☐ Anal cancer *C21.0*
- ☐ Bladder cancer *C67.9*
- ☐ Breast cancer (Female) *C50.919*
- ☐ Breast cancer (Male) *C50.929*
- ☐ Cervical cancer *C53.9*
- ☐ Colon cancer *C18.9*
- ☐ Kidney cancer *C64.9*
- ☐ Ovarian cancer *C56.9*
- ☐ Penile cancer *C60.9*
- ☐ Prostate cancer *C61*
- ☐ Rectal cancer *C20*
- ☐ Small bowel cancer *C17.9*
- ☐ Stomach cancer *C16.9*
- ☐ Urinary tract cancer *C68.9*
- ☐ Uterine (endometrial) cancer *C55*
- ☐ Vulva cancer *C51.9*
- ☐ Other cancer:_____

Eyes
- ☐ Glaucoma *H40.9*
- ☐ Vision loss *H54.7*

Endocrine
- ☐ Adrenal disease *E27.9*
- ☐ Diabetes *E13.9*
- ☐ Hyperthyroidism (high thyroid disease) *E05.90*
- ☐ Hypothyroidism (low thyroid disease) *E03.9*

Gastrointestinal
- ☐ Accidental bowel leakage *R15.9*
- ☐ Anal/Rectal trauma/injury *S36.60*
- ☐ Celiac disease (gluten sensitive) *K90.0*
- ☐ Colon/Rectal polyps *Z86.010*
- ☐ Crohn's disease *K50.90*
- ☐ IBS (Irritable bowel syndrome) *K58.9*
- ☐ Ulcerative colitis *K51.919*

Infection
- ☐ Hepatitis *Z22.50*
- ☐ MRSA *Z22.322*
- ☐ VRE *Z22.39*

Kidney/Urinary
- ☐ Poor kidney function *N28.9*
- ☐ Renal failure *N18.9*
- ☐ Urinary incontinence (leakage of urine) *R32*

Mental Health
- ☐ Anxiety *F41.9*
- ☐ Depression *F32.9*

Musculoskeletal
- ☐ Arthritis *M19.90*
- ☐ Back problems *M53.9*
- ☐ Gout *M10.9*
- ☐ Pelvic fracture *S32.9XXS*

Neurological
- ☐ Multiple sclerosis *G35*
- ☐ Neuropathy *G62.9*
- ☐ Seizures *R56.9*
- ☐ Spinal cord injury
  - ○ Cervical *S14.109A*
  - ○ Thoracic *S24.109A*
  - ○ Lumbar *S34.109A*
  - ○ Sacral *S34.139A*
  - ○ Unknown *Z87.828*
- ☐ Stroke (Cerebrovascular accident) *Z86.73*
- ☐ Brief stroke (Transient ischemic attack-TIA) *Z86.73*

Respiratory
- ☐ Asthma *J45.998*
- ☐ COPD *J44.9*
- ☐ Sleep apnea *G47.30*
- ☐ Other:_____

Female specific
- ☐ Abnormal pap smears
  - ○ Anus *R85.619*
  - ○ Cervix *R87.619*
  - ○ Vaginal *R87.629*
- ☐ Genital warts *A63.0*

Male specific
- ☐ Abnormal Pap smear anus *R85.619*
- ☐ Enlarged Prostate *N40.0*
- ☐ Genital warts *A63.0*

Other medical problem not listed above:

_____

_____

_____

_____

Females Only: Your obstetric History (OBGYN Detail)

Are you pregnant? ☐ **No** ☐ **Yes** **Possible** **Number of pregnancies:**_____**G**

Number of live births:_____**P** **Number of C-Sections:**_____ **Number of vaginal deliveries:**_____

Did you have a tear/laceration during delivery? ☐No ☐Yes Which Pregnancy?___

Did you have an episiotomy during any delivery? ☐No ☐Yes Which Pregnancy?___

Was forcep extraction used for any delivery? ☐No ☐Yes Which Pregnancy?___

Was vacuum extraction used for any delivery? ☐No ☐Yes Which Pregnancy?___

Did you experience Accidental Bowel Leakage (ABL) after any delivery? ☐No ☐Yes Which Pregnancy?___

If yes, how long?_____

If yes, did your accidental bowel leakage (ABL) resolve (stop)? ☐ No ☐Yes Which Pregnancy?___

Did you notice the passage of gas through your vagina after any delivery? ☐No ☐Yes Which Pregnancy?___

Surgery/Procedures – Please check all that apply and indicate the year the surgery was performed.

☐ Please check this box if NO past surgeries.

Abdominal Surgery

- ☐ Appendectomy (appendix) Year_____
- ☐ Cholecystectomy (gallbladder) Year_____
- ☐ Hernia repair Year_____
- ☐ Gastric bypass (weight loss surgery) Year_____
- ☐ Abdominoplasty (tummy tuck) Year_____

Bowel Surgery

- ☐ Colectomy (removal of a portion of large intestine/ Colon) Year_____
- ☐ Small bowel resection (removal of a portion of small Intestine) Year_____
- ☐ Colostomy Year_____
- ☐ Ileostomy stoma Year_____
- ☐ Closure of ileostomy or colostomy Year_____
- ☐ Parks pouch (ileoanal reservoir) Year_____
- ☐ Rectal prolapse repair (abdominal) Year_____
- ☐ Rectal prolapse repair (anorectal) Year_____

Bowel Incontinence Surgery

- ☐ Anal sphincter repair Year_____
- ☐ Sacral nerve stimulation Year_____
- ☐ Other_____ Year_____

Anal or Rectal Surgery

- ☐ Sphincterotomy (fissure surgery) Year_____
- ☐ Fistula surgery Year_____
- ☐ Rectovaginal fistula repair Year_____
- ☐ Hemorrhoid surgery Year_____
- ☐ Pilonidal cyst surgery Year_____
- ☐ Drainage of abscess Year_____

Cardiac (heart)/Vascular (blood vessels)

- ☐ Aortic aneurysm repair/Aortic bypass Year_____
- ☐ Cardiac pacemaker Year_____
- ☐ Defibrillator Year_____
- ☐ Heart stents Year_____
- ☐ Heart valve placement Year_____
- ☐ Coronary bypass (CABG) Year_____

Transplant Surgery

- ☐ Heart Year_____
- ☐ Lung Year_____
- ☐ Kidney Year_____
- ☐ Liver Year_____

Orthopedic Surgery

- ☐ Hip replacement Year_____
- ☐ Knee replacement Year_____
- ☐ Back surgery
  - ○ Cervical Year_____
  - ○ Lumbar Year_____
  - ○ Thoracic Year_____

Female Specific Surgery

- ☐ Breast augmentation Year_____
- ☐ Mastectomy Year_____
- ☐ Cervical procedure Year_____
- ☐ C-section Year_____
- ☐ Hysterectomy – Abdominal Year_____
- ☐ Hysterectomy – Vaginal Year_____
- ☐ Removal of tubes and ovaries Year_____
- ☐ Infertility surgery Year_____
- ☐ Rectocele/Enterocele repair Year_____
- ☐ Urinary incontinence procedure Year_____
- ☐ Bladder repair/cystocele repair Year_____
- ☐ Sling Year_____
- ☐ Vaginal prolapse repair Year_____

Male Specific Surgery

- ☐ Removal of prostate Year_____
- ☐ Prostate radiation Year_____

Miscellaneous Surgery

- ☐ Dental/Oral surgery Year_____
- ☐ Tonsillectomy Year_____
- ☐ Other_____ Year_____

Other Surgery

- ☐ Other_____ Year_____
- ☐ Other_____ Year_____

Have you had any major problems with anesthesia? ☐ No ☐ Yes_____

Have you had any excessive bleeding problems with surgery? ☐ No ☐ Yes_____

Diagnostic Studies – Please check all that apply and indicate location and date study was performed.

☐ Please check this box if NO diagnostic studies have ever been performed

- ☐ Colonoscopy Location/Facility:_____ Date:_____
- ☐ Flexible Sigmoidoscopy Location/Facility:_____ Date:_____
- ☐ CT of Abdomen/Pelvis Location/Facility:_____ Date:_____
- ☐ CT-PET Location/Facility:_____ Date:_____
- ☐ Transit Time Study Location/Facility:_____ Date:_____
- ☐ Mammogram (Females) Location/Facility:_____ Date:_____
- ☐ Anal Pap (cytology) Location/Facility:_____ Date:_____

Family History – For any of your family members, please check all that apply.

☐ Please check this box if NO relevant family history.

If yes, please indicate the relationship of the family member and if that member was maternal (mother's side) or paternal (father's side)

	Family Member	Maternal or Paternal	Age Diagnosed	Age Deceased
Colon Cancer				
Rectal Cancer				
Celiac Disease				
Colon Polyps				
Crohn's Disease				
Ulcerative Colitis				
Cancer:				
Bile Duct/Gallbladder Cancer				
Bladder Cancer				
Brain Cancer				
Breast Cancer				
Endometrial Cancer				
Gastric (Stomach) Cancer				
Kidney Cancer				
Ovarian Cancer				
Small Intestine/Small Bowel Cancer				
Uterine Cancer				
Other Cancer				
Factor V Leiden Deficiency				
Hemophilia				
Malignant Hyperthemia				
Von Willebrand's Disease				

Personal Habits / Social History

Have you ever used tobacco? ☐ No/Never ☐ Yes ☐ Formerly—Age Quit:_____

Smoking Tobacco Use (former and current):

- ☐ Cigarette _____cigarettes/packs per day
- ☐ Cigarillo _____per day
- ☐ Cigar _____per day
- ☐ Pipe _____per day

Non-Smoking Tobacco Use (former and current):

- ☐ Chewing _____units per day
- ☐ E-cig _____units per day
- ☐ Snuff _____units per day

Do you consume alcohol? ☐ No/Never ☐ Yes ☐ Formerly (in the past) **Type:** ☐ Beer ☐ Wine ☐ Liquor

How many drinks per day? ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10+ **How often?**_____

Do you consume caffeine? No/Never Yes **Type:** Coffee Soda Energy drinks

How many drinks per day? ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10+ **How often?**_____

Are you currently: ☐ Single ☐ Married ☐ Partnered

Are you currently employed? ☐ No ☐ Yes ☐ Full-time ☐ Part-time ☐ Disabled

Occupation (required):_____

Retired? ☐ Yes ☐ No **Previous occupation:** _____

Have you ever used illicit drugs? ☐ No ☐ Yes ☐ Formerly (in the past)

Have you ever had anal sex? ☐ No ☐ Yes

HIV Status: ☐ Negative ☐ Positive ☐ Not Tested

Communicable Disease-Please provide the information below:

All patients are being screened for communicable diseases

Have you lived or traveled to a country with widespread Ebola virus transmission	☐ No	☐ Yes
Have you had contact with an individual with confirmed Ebola Virus Disease in the last 21 days?	☐ No	☐ Yes
Do you have tuberculosis (TB)?	☐ No	☐ Yes
Do you have measles?	☐ No	☐ Yes
Do you have chickenpox or shingles?	☐ No	☐ Yes
Do you have any other infectious diseases (including MRSA, C.Diff, VRE, CRE, CRKP)	☐ No	☐ Yes

Patient Demographics:

Primary Care Provider: _____ **Provider phone number:** _____

Preferred pharmacy name:_____ **Pharmacy Phone:**_____

Pharmacy address:_____

In the event of a medical emergency, who may we contact? Name:_____

Relationship:_____Phone:_____

NOTICE OF NONDISCRIMINATION

Colon and Rectal Surgery Inc and The Colonoscopy Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Colon and Rectal Surgery Inc and The Colonoscopy Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Colon and Rectal Surgery Inc and The Colonoscopy Center:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please notify us when scheduling your appointment.

If you believe that Colon and Rectal Surgery Inc and The Colonoscopy Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Administrator
9850 Nicholas Street, Suite 100
Omaha NE 68114
Phone: (402) 343-1122
Fax: (402) 343-1177

You can file a grievance in person or by mail, or fax. If you need help filing a grievance, Colon and Rectal Surgery Inc and The Colonoscopy Center's Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F,
HHH Building,
Washington, DC 20201
1-800-368-1019
800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak another language, assistance services, free of charge, are available to you. Call 1-402-343-1122.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-402-343-1122.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-402-343-1122.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-402-343-1122.

ة العربي (Arabic)
402-343-1122- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 1

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-402-343-1122

Oroomiffa (Oromo)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-402-343-1122

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-402-343-1122

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-402-343-1122 번으로 전화해 주십시오.

नेपाली (Nepali)
□यान िदनुहोस:् तपाइलर्ं े नेपाली बो□नुहु□छ भने तपाइकर्ं ो िनि□त भाषा सहायता सेवाह□ िनःश□ु क □पमा उपल□ध छ । फोन गनुहर् ोस ्1-402-343-1122

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-402-343-1122.

ພາສາລາວ (Laotian)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິ ການຊ່ ວຍເຫຼື ອດ້ ານພາສາ, ໂດຍບໍ່ ເສັ ງຄ່ າ, ແມ່ ນມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-402-343-1122

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-402-3431122 まで、お電話にてご連絡ください。

Kurdish
ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە.

پەیوەندی بە 1-402-343-1122 بکە.

Karen
ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ. နမၤန့ၢ် ကျိာ်အတ်မၤစၢၤလ၊ တလၢာ်ဘူဉ်လၢာ်စ့ၢ် နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-402-343-1122.

Persian Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-402-343-1122 تماس بگیرید.