

Notice of Privacy Practices

<p>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.</p> <p>How We Use Your Patient Health Information We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.</p> <p>Examples of Treatment, Payment, and Health Care Operations <u>Treatment:</u> 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 with your care. <u>Payment:</u> 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. We will submit bills and maintain records of payments from your health plan. <u>Health Care Operations:</u> 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, and to assess the care and outcomes of your case and others like it.</p> <p>Special Uses We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.</p>	<p>Other Uses and Disclosures We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. Research: We may use or disclose information for approved medical research. <u>Public Health Activities:</u> As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities. <u>Health oversight:</u> We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities. <u>Judicial and administrative proceedings:</u> We may disclose information in response to an appropriate subpoena or court order. <u>Law enforcement purposes:</u> Subject to certain restrictions, we may disclose information required by law enforcement officials. <u>Deaths:</u> We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. <u>Serious threat to health or safety:</u> 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. <u>Military and Special Government Functions:</u> 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. <u>Workers Compensation:</u> We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any 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.</p>	<p>Individual Rights You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. <u>Request Restrictions:</u> You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request. <u>Confidential Communications:</u> 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. <u>Inspect and Obtain Copies:</u> 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 the copies. <u>Amend Information:</u> If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information. <u>Accounting of Disclosures:</u> You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations. 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. Changes in Privacy Practices We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.</p>
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Release of Medical Information

I authorize Specialists in Gastroenterology to use/or disclose certain medical and/or billing information to(ex. Spouse, Family Member, etc...):

Restrictions on the Disclosure of Medical Information

- You can leave a detailed message (including billing, test results, medical information)
- You may leave a message with no details except a call back number and "Specialists in Gastroenterology" identified
- You may not leave a message

Signature: _____ Date: _____
Patient or Legal Guardian

Printed Name: _____ DOB: _____



Assignment of Benefits

Some insurance companies will not pay your bill if you do not select one of their participating doctors. It is the patient's responsibility to determine if our doctor participates in your plan. Payment or co-payment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. If I default in payment I understand that I will be responsible for any collection and/or legal fees.

Screening vs. Diagnostic Coverage

Insurance companies often provide screening benefits for routine screening colonoscopy. However, if during your screening procedure the physician removes a polyp or performs a biopsy, the procedure may be considered diagnostic and may not be covered as a screening exam. In this case, some insurance companies drop financial responsibility to the patient for all or part of the procedure cost. It is important for you to know if this applies to your routine screening benefits.

Patient Name

Date of Birth

Signature (patient or guardian)

Date



specialists in gastroenterology

Registration Form

Patient Information

Name: Last First Middle Initial Nickname Gender: Male Female

Address: Street City State Zip Code

Social Security Number: - - DOB:

Home Phone: () Cell Phone: () Email:

Ethnicity: Non Hispanic or Latino Hispanic or Latino Declined Race: White Asian Declined Black/African American Native Hawaiian/Pacific Islander Declined American Indian/Alaska Native Other

Preferred Language: English Spanish Other:

Marital Status: Spouse's Name: Spouse's DOB:

Spouse's Social Security Number - - Spouse's Phone: ()

Spouse's Employer: Company Name Phone Number Spouse's Occupation:

In Case of Emergency Contact: Name Relation Phone Number

Responsible Party (If Patient is Under 18)

Name: Last First Middle Initial Nickname

Address: Street City State Zip Code

Home Phone: () Cell Phone: () Email:

Employer: Company Name Phone Number Occupation:

Physician Information

Primary Care Physician: Phone Number: ()

Referring Physician: Phone Number: ()

Medical Insurance Information

Primary Insurance Company:

Policy Number: Group Number:

Policy Holder: Policy Holder DOB: Relationship To Policy Holder:

Secondary Insurance Company:

Policy Number: Group Number:

Policy Holder: Policy Holder DOB: Relationship To Policy Holder:

Signature

Date Of Birth

Legal Guardian Signature (If other than Patient)

Date

New Patient Form Name: _____ DOB: _____ Date: _____

What is your main problem?:

Date of onset or length of symptoms: _____ If it is pain, how long does it last: _____
Severity of this problem on a scale of 0 to 10 or state how severe it is to you: _____
Is it unchanged or worsening? _____
If it is pain, where is it located? _____ If moves where does it go? _____
If it is pain, what words would you use to describe it? _____
For this problem, when does it usually occur (i.e., after meals, with stress, est.)? _____
What makes it worse? _____
What makes it better? _____
What other symptoms occur at the same time? _____

Second Problem (if applicable):

Date of onset or length of symptoms: _____ If it is pain, how long does it last: _____
Severity of this problem on a scale of 0 to 10 or state how severe it is to you: _____
Is it unchanged or worsening? _____
If it is pain, where is it located? _____ If moves where does it go? _____
If it is pain, what words would you use to describe it? _____
For this problem, when does it usually occur (i.e., after meals, with stress, est.)? _____
What makes it worse? _____
What makes it better? _____
What other symptoms occur at the same time? _____

Other important information:

Colonoscopy and Upper Endoscopy: If performed, give result and year; obtain records if possible.

Radiology study (CAT scan, upper GI, etc): if applicable, result and year; obtain records if possible.

Lab studies (CBC, chemistry, liver profile, etc): obtain records of recent or important results.

Immunizations: State "Yes" if up-to-date, "No" if never had or not up-to-date, of "?" if unsure:
Hepatitis A _____; Hepatitis B _____; HPV _____; Tetanus _____; Influenza in the last year _____;
Pneumovax _____; Shingles _____; TB testing (date of test) _____

List of surgeries:

Gastrointestinal Family History: colon cancer/polyps, celiac disease, colitis, Crohn's disease, gallbladder stones/surgery, irritable bowel syndrome, liver disease, osteoporosis, ulcers, ulcerative colitis, pancreatitis
Diagnosis/Relationship (example: Colon cancer/Father): please include parents, siblings and grandparents

