GASTROINTESTINAL ASSOCIATES, L.L.P.

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Dear,

Thank you for choosing G.I. Associates. Please complete the enclosed paperwork. Bring the paperwork, along with your insurance card and copay to your visit scheduled for:

Doctor _____

Day _____

Date _____

Time _____

If this appointment is not convenient, please phone our office as soon as possible to reschedule.

Directions to the Office (Portland is the street located behind Columbia Regional Hospital)

- **From Highway 63 South:** Take the Broadway exit, turn left. At the next light, turn left onto Keene Street. Follow Keene Street to Portland Street, turn right onto Portland Street. The Endoscopy Center is on the right, just past Boyce and Bynum Laboratories. G.I. Associates is located behind the Endoscopy Center.

- **From Highway 63 North:** Take the Broadway exit, turn right. At the second light, turn left onto Keene Street. Follow Keene Street to Portland Street, turn right on Portland Street. The Endoscopy Center is on the right, just past Boyce and Bynum Laboratories. G.I. Associates is located behind the Endoscopy Center.

- **From Interstate 70:** Take the Highway 63 South exit. Proceed on 63 South to the Broadway exit, turn left. At the second light, turn left on Keene Street. Follow Keene Street to Portland Street, turn right on Portland Street. The Endoscopy Center is on the right, just past Boyce and Bynum Laboratories. G.I. Associates is located behind the Endoscopy Center.

Sincerely,

G.I. Associates, L.L.P.

Name:
Chart:
Date:

Reason for today's visit: _____

_____

(Check those which have occurred recently)

General
__ Weight gain
__ Weight loss
__ Weakness
__ Fatigue
__ Fever
__ Chills
__ Night sweats

Lungs
__ Cough
__ Blood in Sputum
__ Short of breath
__ Wheezing

Heart
__ Murmur
__ Palpitations
__ Rapid Heartbeat
__ Swollen legs
__ Chest pain
__ Chest Pressure
__ Blood clots

Blood
__ Anemia
__ Low Blood Iron
__ Easy bruising
__ Easy bleeding

Gastrointestinal
__ Abdominal Pain
__ Nausea __ Vomiting
__ Bloating
__ Belching
__ Heartburn __ Indigestion
__ Irregular bowels
__ Constipation

Gastrointestinal
__ Diarrhea
__ Gas
__ Hemorrhoids
__ Hernia
__ Poor appetite
__ Bloody stools
__ Black stools
__ Trouble swallowing

Genitourinary
__ Urgency
__ Frequent voiding
__ Stones
__ Burning
__ Bloody urine

Musculoskeletal
__ Muscle pain
__ Muscle weakness
__ Muscle cramps
__ Joint pain/swelling
__ Back pain

Psychiatric
__ Anxiety
__ Depression
__ Drug Dependency
__ Suicidal tendency

PAST MEDICAL HISTORY:

Anemia:
__ Iron Deficiency
__ Vitamin B12 Deficiency

Blood Diseases:
__ Leukemia
__ Bleeding Disorder
__ Blood Clots

Cancer:
Type _____

Cardiovascular:
__ Heart Attack
__ Heart Stents
__ Murmur
__ Hypertension
__ High Cholesterol
__ High Triglycerides
__ Angina/Chest Pain
__ Heart valve

Endocrine:
__ Diabetes
__ Thyroid

ENT:
__ Sinusitis

Liver:
__ Jaundice
__ Hepatitis

MISC:
__ Gout
__ Arthritis
__ Skin Problems
__ Muscle Problems
__ Hernia

Pulmonary:
__ Bronchitis
__ Emphysema
__ Pneumonia
__ Asthma

Gastrointestinal:
__ Ulcer
__ Gastritis
__ Irritable Bowel
__ Hiatal Hernia
__ Gallstones
__ Pancreatitis
__ Colon Polyp
__ Diverticulosis
__ Diverticulitis
__ Ulcerative Colltis
__ Crohns
__ Bowel Obstruction
__ Fissure/Abscess

Genitourinary:
__ Kidney Infection
__ Kidney Stone(s)
__ Bladder Trouble
__ Prostate Growth
__ Gynecological Problems

Neurology:
__ Epilepsy
__ Multiple Sclerosis
__ Stroke/TIA
__ Paralysis
__ Headaches

PERSONAL AND FAMILY MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

HISTORY # _____

DO YOU HAVE OR HAVE YOU EVER HAD: HAS ANY BLOOD RELATIVE EVER HAD:

CANCER	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
TUBERCULOSIS	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
ASTHMA	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
EMPHYSEMA	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
LUNG DISEASE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
DIABETES	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
HEART DISEASE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
HIGH BLOOD PRESSURE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
EPILEPSY OR CONVULSIONS	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
MIGRAINE HEADACHES	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
KIDNEY STONES	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
KIDNEY DISEASE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
LIVER DISEASE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
COLON OR BOWEL TROUBLE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
STOMACH OR DUODENAL ULCER	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
BLEEDING DISORDER	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
GLAUCOMA	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
GOUT, ARTHRITIS	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
OTHER JOINT DISEASE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
THYROID DISEASE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
SKIN DISEASE/CANCER	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
BREAST DISEASE	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
SICKLE CELL ANEMIA	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
MENTAL ILLNESS	◯NO ◯YES	WHEN _____	◯NO	◯YES	WHO _____	
SYPHILIS OR V.D.	◯NO ◯YES	WHEN _____	SUICIDE	◯NO	◯YES _____	
					WHO _____	

LIST ALL OPERATIONS:

1. WHEN _____ WHAT _____
2. WHEN _____ WHAT _____
3. WHEN _____ WHAT _____
4. WHEN _____ WHAT _____

LIST OTHER HOSPITALIZATIONS:

1. WHEN _____ WHAT _____
2. WHEN _____ WHAT _____
3. WHEN _____ WHAT _____
4. WHEN _____ WHAT _____

DO YOU DRINK ALCOHOLIC BEVERAGES? ◯NO ◯YES HOW MUCH _____

DO YOU SMOKE OR HAVE YOU SMOKED? ◯NO ◯YES HOW MUCH AND HOW LONG _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

ANTIBIOTICS ◯NO ◯YES WHAT _____

OTHER DRUGS OR MEDICINES ◯NO ◯YES WHAT _____

ANY FOODS ◯NO ◯YES WHAT _____

OTHER _____

CIRCLE ANY OF THE FOLLOWING DISEASES THAT YOU HAVE HAD: MEASLES, MUMPS, CHICKEN POX, POLIO, RHEUMATIC FEVER

DO YOU HAVE OR HAVE YOU EVER HAD:

WOMEN:

MENSTRUAL DIFFICULTIES ◯NO ◯YES WHEN _____

AGE PERIODS STARTED _____ AGE PERIODS STOPPED _____

NUMBER OF TIMES PREGNANT _____ NUMBER OF CHILDREN _____ NUMBER OF MISCARRIAGES _____

MEN:

PROSTATE TROUBLE ◯NO ◯YES WHEN _____

	LIVING	DEAD	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER OR SISTER				
HUSBAND OR WIFE				
SON OR DAUGHTER				

Name:
Med Record #: DOB:
Date:

517206-3

Gastrointestinal Associates, LLP - Medication List

Allergies: _____

Medication Name	How much? (Strength/ Dosage)	How often do you take it?					

G.I. Meds 1-16-09

Name:
Chart:
Date:

517206-45

GASTROINTESTINAL ASSOCIATES, L.L.P.

Hx# _____

CONSENT FOR MEDICAL CARE

Recognizing the need for medical care for the patient whose name appears on this form, I do voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by the physicians of Gastrointestinal Associates, LLP and their assistants or designees as is necessary. I understand that, other than in the case of emergency treatment, I will have the opportunity to participate in the process by which decisions are made about the patient's care. I also understand that I will be asked to sign separate consent forms for the authorization of any non-routine procedures and treatments the patient might require.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of the examination or medical treatment of Gastrointestinal Associates, LLP.

I authorize Gastrointestinal Associates, LLP. to furnish requested information or excerpts from the patient's record to any insurance company, health plan or sponsoring agency who may be providing financial assistance for medical care (as well as any agents or review agencies necessary for processing any claim), including Medicare and Medicaid, for the purpose of obtaining payment; and to any physician, hospital laboratory, radiological facility or other health care provider from which the patient has been referred or to which the patient is being referred as is necessary to support continuity of care. I understand that these medical records may include all information relative to the patient's physical condition, past and present, including the diagnosis and history of the patient's case, psychiatric history and alcohol or drug abuse information.

I authorize payment of medical benefits to the Gastrointestinal Associates, LLP. for services provided to the patient. I also authorize payment of government benefits to Gastrointestinal Associates, LLP.

I accept full financial responsibility for services received by the patient which are not covered by government benefits or any type of insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to Gastrointestinal Associates, LLP. at the time of services. I also understand that I am responsible for obtaining all referrals or authorizations required by my insurance.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND AM AUTHORIZED TO CONSENT FOR MEDICAL CARE OF THE PATIENT.

Print Patient Name: _____

Signature of Patient or Authorizing Person:

_____ Date: _____

Signature of Witness

_____ Date: _____

_____

Relationship to Patient

Authorization must be signed by the patient, by a parent if the patient is a minor, or by a guardian if the patient is incapacitated.

Revised 03/19/2009

Name:
Chart:
Date:

Consent to Use Protected Health Information

To provide for your healthcare, **Gastrointestinal Associates, LLP** collects information about your medical history, physical examinations and test results, diagnoses, and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Under HIPAA, providers of healthcare may decide to obtain your consent to use personal health information for treatment, payment, or healthcare operations, but are not required to do so.

Therefore, I, _____ (printed name of patient or personal representative), consent that **physician** may use the health information of

(check one) ☐ myself or ☐ (specify): _____ for the following purposes:

(If signing as a personal representative, documentation of your legal right to do so must be provided.)

1. Treatment (to perform actions required to help diagnose, maintain, or improve health);
2. Payment (to obtain reimbursement from third party payers);
3. Healthcare operations (to carry out, analyze, or improve business processes related to healthcare).

Physician has privacy practices that are summarized in our Notice of Privacy Practices for Protected Health Information ("Notice"). This Notice describes the use and disclosure of protected health information, patients' rights relevant to examining medical records, requesting corrections and additions to these records, requesting restrictions to the use of health information, finding out to whom their protected health information has been disclosed, and registering any complaints relevant to privacy issues. The Notice also describes how to receive these rights. I have been provided with or have previously received a copy of this Notice and given the opportunity to review it prior to signing this consent. I understand that if I decide not to sign this consent, **Physician** may decline to provide healthcare to me.

The consent I am signing today covers this and all future healthcare activities performed for me by **Physician** with respect to treatment, payment, and operations. This consent replaces and supercedes any previous consents, I may have signed with **Physician** for such use of my healthcare information. If I wish to revoke this consent, such a request must made be in writing. However, a revocation does not cover actions that have already been taken in reliance upon the consent previously in force. In addition, I understand that if I revoke this consent, then **Physician** may discontinue taking care of me.

Unless I object, my name and location may be disclosed to anyone asking for me by name. Unless I request otherwise, information about my health may be disclosed to other people involved in my healthcare (e.g., family members, personal representatives, those accompanying you for care). Unless I object, my religious affiliation may be disclosed to members of the clergy.

I have the right to request restrictions or limitations as to how my protected health information will be used to carry out treatment, payment, or healthcare operations. I understand that HIPAA does not require such requests to be accepted, but if restrictions are accepted, then they must be honored. I request the following restrictions to the use and/or disclosure of my health information ☐ **NONE or list below:**

_____

_____

Signature of Patient or Personal Representative	/ /20 Date (mm/dd/yyyy)	Witness	/ /20 Date (mm/dd/yyyy)

To be completed by Physician

Printed Name	Title	Signature	/ /20 Date

If restrictions are requested, an individual authorized to approve such restrictions must sign. *(mm/dd/yyyy)*

Name:
Chart:
Date:

517206-45

Summary of Notice of Privacy Practices

A new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") goes into force on April 14, 2003. We are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgement that you have received our Notice. That acknowledgement is on the reverse side of this Summary Notice.

Your Rights as a Patient. You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information. We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible.

For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

Disclosures of Protected Health Information Requiring Your Authorization. For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

Disclosures of Protected Health Information Not Requiring Your Authorization. We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Communication to You of Confidential Information by Alternative Means. If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

Restrictions to Use and Disclosure. You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

Access to Protected Health Information. You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the

Amendments to Medical Records. You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical

Accounting of Disclosures of Protected Health Information. You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written
Other Uses of Your Health Information. Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

How to Lodge Complaints Related to Perceived Violations of Your Privacy Rights. You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation.