Patients who completed registration on the Patient Portal only need to complete pages/areas indicated in red rectangles.

Gastro One
Excellence in Digestive Health

DATE _____ **REFERRED BY** _____ CHART # _____

PATIENT INFORMATION

NAME: (first) _____(middle initial) _____ (last) _____

BIRTH DATE: _____/_____/_____ **GENDER**: ☐FEMALE ☐ MALE **SOCIAL SECURITY #**: _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP CODE**: _____

HOME PHONE: _____ **WORK PHONE**: _____ **MOBILE PHONE**: _____ **EMAIL**: _____

CONTACT PREFERENCE: ☐ MOBILE PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ PATIENT PORTAL ☐ OTHER_____

I WOULD LIKE TO RECEIVE PREVENTIVE CARE AND FOLLOW UP CARE REMINDERS: ☐YES ☐NO

I CONSENT TO HAVING MY MEDICAL & DEMOGRAPHIC INFORMATION SHARED WITH OTHER HEALTH CARE FACILITIES: ☐YES ☐NO

PHARMACY NAME: _____ **ADDRESS**:_____ **PHONE**:_____

RACE: ☐WHITE/CAUCASIAN ☐ BLACK/AFRICAN AMERICAN ☐ASIAN ☐AMERICAN INDIAN OR ALASKA NATIVE

☐NATIVE HAWAIIAN/PACIFIC ISLANDER ☐MIXED ☐OTHER ☐UNKNOWN ☐I DECLINE TO PROVIDE INFORMATION

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO ☐I DECLINE TO PROVIDE INFORMATION

PREFERRED LANGUAGE:☐ENGLISH ☐SPANISH ☐OTHER _____ **MARITAL STATUS** :☐SINGLE☐MARRIED☐DIVORCED☐WIDOWED

EMPLOYER NAME: _____**ADDRESS:**_____

EMERGENCY CONTACT: _____ **RELATIONSHIP**: _____ **PHONE**: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

INSURANCE CO. ADDRESS: _____

NAME OF POLICYHOLDER: _____ **DATE OF BIRTH**: _____

ID OR SOC SECURITY #: _____ **GROUP #**: _____ **RELATIONSHIP TO PATIENT**: _____

POLICYHOLDER'S ADDRESS (IF other than patient): _____

POLICYHOLDER'S EMPLOYER (IF other than patient): _____ **PHONE #**: _____

POLICYHOLDER EMPLOYER'S ADDRESS (IF other than patient): _____

SECONDARY INSURANCE COMPANY NAME: _____

INSURANCE CO. ADDRESS: _____

NAME OF POLICYHOLDER: _____ **DATE OF BIRTH**:_____

ID OR SOC SECURITY #: _____ **GROUP #**: _____ **RELATIONSHIP TO PATIENT**: _____

POLICYHOLDER'S ADDRESS (IF other than patient): _____

POLICYHOLDER'S EMPLOYER (IF other than patient): _____ **PHONE #**: _____

POLICYHOLDER EMPLOYER'S ADDRESS (IF other than patient): _____

Gastro One
Excellence in Digestive Health

G.I. Diagnostic and Therapeutic Center, L.L.C.

- 8000 Wolf River Blvd., #200, Germantown, TN 38138
- 1310 Wolf Park Drive, Germantown, TN 38138
- 1324 Wolf Park Drive, Germantown, TN 38138
- 2999 Center Oak Way, Germantown, TN 38138
- 3350 N Germantown Road, Bartlett, TN 38133
- 7668 Airways Blvd., Building B, Southaven, MS 38671

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release or disclose of all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____

☐ **I hereby authorize the release of my medical records TO GASTRO ONE from ALL MEDICAL SOURCES so that my physician has the information he/she needs to provide medical care.**

☐ I only authorize the release of my medical records from _____ **TO GASTRO ONE**

☐ I hereby authorize the release of my medical records at **GASTRO ONE** to the following:

_____

Purpose of the disclosure is for medical care unless otherwise specified here:

_____

The authorization will expire on: _____

Date or Event may not exceed one year

This authorization applies to:

☐**All medical records**

☐Health care information only relating to the following treatment(s), condition (s) or dates of treatment:

_____

☐ Limited records to be released (examples lab work reports, imaging reports), specify:

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box indicating the information you do not want released or specify: _____

_____

☐Substance abuse ☐Psychological or psychiatric treatment ☐HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient

Gastro One
Excellence in Digestive Health

Patient Interview Form

First Name_____Last Name_____

Allergies □ None □ Penicillin □ Sulfa □ Latex □ Iodine □ Eggs □ Others _____

Current Medications Please list meds below including non-prescription medications (use back if needed)

□ None

Name Dose How Taken

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I consent to obtaining a history of my medications purchased at pharmacies. □ yes □ no

Immunizations □ None □ Hep A □ Hep B □ Flu □ Pneumonia □ TB
Date _____ _____ _____ _____ _____

Diagnostic Studies □ None □ Colonoscopy □ Endoscopy
Date _____ _____

Past or Present Medical Conditions

GI Related Illnesses: □ None

□ Cirrhosis □ Colon cancer □ Colon polyps □ Crohn's Disease
□ Diverticulitis □ Esophagitis/GERD □ Gallstones □ Hepatitis
□ Irritable Bowel □ Pancreatitis □ Stomach /Duodenal Ulcer

Other Illnesses: □ None

□ Bleeding Disorder □ Anemia □ Arterial blockages □ Asthma
□ Blood Transfusions □ Diabetes Mellitus □ Endometriosis □ Fibromyalgia
□ Glaucoma □ Coronary Disease □ Heart Failure □ High blood pressure
□ High Cholesterol □ HIV/AIDS □ Kidney Disease/Failure □ Lupus
□ Osteoporosis □ Seizures □ Sleep apnea □ Stroke or Paralysis
□ TB or positive TB skin test □ Thyroid Disease □ Rheumatoid Arthritis
□ Cancer_____

□ Other illnesses_____

_____

Previous Surgeries: □ None

□ Appendectomy □ CABG □ Heart Valve □ Colon Resection
□ Gallbladder removed □ Hemorrhoidectomy □ Hiatal Hernia □ Hysterectomy
□ Obesity Surgery □ Ovary Surgery □ Stomach Surgery □ Tubal Ligation
□ Other surgeries_____

_____

Social History

Occupation_____

Marital Status □ Single □ Married □ Divorced □ Widowed

Alcohol Use □ None □ < 5 drinks per wk □ 5 to 15 drinks per wk □ > 15 drinks per wk

Tobacco Use □ None □ < 1 pack per day □ 1-2 packs per day □ > 2 packs per day
□ Former smoker

Recreational Drug Use □ None □ Marijuana □ Cocaine □ Other_____

Exercise □ None □ < 3 days per week □ 3-5 days per week □ > 5 days per week

Family Medical History

Do you have any family history of the following:

□ No knowledge of family history

□ Family history of colon cancer Who_____Age_____

□ Family history of colon polyps Who_____Age_____

□ Celiac disease Who _____

□ Crohn's disease Who _____

□ Ulcerative colitis Who _____

□ Esophageal cancer Who _____

□ Ovarian cancer Who _____

□ Pancreatic cancer Who _____

□ Stomach cancer Who _____

□ Uterine cancer Who _____

Review Of Systems Check the boxes for symptoms you have had during the last 6 months.

Cardiovascular

□ Ankle Swelling

□ Chest pain

□ Irregular heart beat

Constitutional

□ Fatique

□ Fever

□ Loss of appetite

□ Weight gain

□ Weight loss

Ears/Nose/Mouth/Throat

□ Hoarseness

□ Sore Throat

Endocrine

□ Excessive Thirst

□ Cold Intolerance

□ Heat Intolerance

Gastrointestinal

□ Abdominal Pain

□ Belching

□ Black Stools

□ Bloating

□ Change in Bowel Habit

□ Constipation

□ Dairy Intolerance

□ Diarrhea

□ Difficulty Swallowing

□ Painful Swallowing

□ Flatulence/rectal gas

□ Heartburn/Reflux

□ Nausea

□ Painful stools

□ Rectal Bleeding

□ Rectal Protrusions

□ Rectal Urgency

□ Soiling/Incontinence

□ Vomiting

Hematologic/Lymphatic

□ Easy Bruising

□ Prolonged Bleeding

Integumentary

□ Itching

□ Jaundice

□ Rash

Musculoskeletal

□ Back Pain

□ Joint Pain

□ Muscle Pain

Neurological

□ Dizziness

□ Fainting

□ Frequent Headaches

Psychiatric

□ Anxiety / Panic

□ Depression

□ Difficulty Sleeping

Respiratory

□ Chronic Cough

□ Shortness of Breath

GASTRO ONE
G.I. DIAGNOSTIC AND THERAPEUTIC CENTER, L.L.C.

APPOINTMENT REQUEST (Please check one)

You have asked to see a Gastro One physician **or** your physician has recommended one of the physicians at Gastro One.

[ ] SELF REQUESTED

[ ] PHYSICIAN REQUESTED

Full Name of the physician requesting an evaluation from a Gastro One physician.

_____

EMERGENCY CARE

In the event of a life threatening emergency, it is the policy of Gastro One to perform Cardiopulmonary Resuscitation (CPR) as necessary to stabilize our patients for transfer to an acute care health facility.

( ) YES ( ) NO DO YOU HAVE A LIVING WILL?

( ) YES ( ) NO ARE YOU AN ORGAN DONOR?

COMMUNICATIONS REGARDING YOUR HEALTH CARE INFORMATION

Please indicate with whom we may discuss your healthcare. Check all that apply.

( ) I hereby authorize Gastro One to leave messages regarding pending appointments or tests at my residence.

( ) Gastro One may communicate information regarding my healthcare with the individuals listed below:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

( ) Gastro One may not communicate my healthcare information with anyone other than me.

CONSENT FOR CARE

The physicians & staff of Gastro One &/or the G.I. Diagnostic and Therapeutic Center, L.L.C. will be hereafter referred to as "Gastro One". I hereby give my consent for treatment. My signature on this form indicates I have received a copy of the "Notice of Privacy Practices" from Gastro One and I understand how my health care information will be used and /or disclosed.

MEDICARE EXTENDED PAYMENT REQUEST

(one time authorization)

I request payment of authorized Medicare benefits to be made either to me or on my behalf to: the physicians of Gastro One and/or G. I. Diagnostic & Therapeutic Center, L.L.C. for any services provided to me. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicaid Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL POLICY

Please familiarize yourself with your healthcare coverage. We are committed to providing our patients with the best possible care. If you have medical insurance, we will do all that we can to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. If you are enrolled in a managed care plan, you are responsible for informing Gastro One of any special requirements of your insurance plan. If lab work or other diagnostic tests are ordered and sent to an outside lab or other facility, you will be billed directly by the outside lab or facility and payment is your responsibility. We will file your insurance claim for you; however, **we ask that you pay any co-payment or deductible at the time our services are rendered** and the balance in full within 90 days regardless of insurance filing. We accept Cash, Check, American Express, Discover, MasterCard, or Visa. We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If your account is turned over to a professional collection agency you may be dismissed from care by physicians employed by Gastro One &/or G.I. Diagnostic & Therapeutic Center, L.L.C.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you. I have read and understand this explanation of the financial policy of Gastro One and hereby authorize the release of any medical information deemed necessary to process any insurance claim for services rendered. This form is authorization for all medical benefits from any insurance company on said claims to be paid directly to Gastro One &/or G.I. Diagnostic & Therapeutic Center, L.L.C.

"No Show" Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations. However, when you do not call to cancel an appointment, another patient may be prevented from receiving needed care.

As part of our continued effort to provide you with the best care and accommodate all appointment requests, Gastro One has implemented a "No Show" Fee Policy. If you fail to show up for your scheduled appointment, Gastro One and G.I. Diagnostic & Therapeutic Center reserve the right to charge a fee of **$25.00 for all missed office visits and $75.00 for all missed procedure appointments**.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of our patients.

My signature indicates I have read and understand the information on the front and back of this form.

Signature_____Date_____

GASTRO ONE

G.I. DIAGNOSTIC AND THERAPEUTIC CENTER, L.L.C.

Notice of Privacy Practices for Protected Health Information

The office is permitted by federal privacy laws to make uses and disclosuresof your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, diagnoses, treatment, test results, and applying for future care or treatment. It also includes billing documents for those services. Examples of uses of your health information for treatment purposes are: A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input. Example of use of your health information for payment purposes: We submit requests for payment to your health insurance company. A health insurance company or business associate helping us obtain payment requests information from us regarding your medical care. We will provide information to them about you and the care given. Examples of Use of Your Information for health care operations: We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

Patient Health Information Rights - The health and billing records we maintain are the physical property of the practice. You have the following rights with respect to your protected health information: to request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will attempt to comply with any reasonable; to obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office; to inspect and copy your health record andbilling record -you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; to request that your health care record be amended to correct incomplete or incorrect information appeal a denial of access to your protected health information except in certain circumstances; by delivering a written request to our office using the form we provide to you upon request. (The physician or other health careprovider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information; to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care; to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request. If you want to exercise any of the above rights, please contact the supervisor of your respective practice site during normal hours. All requests should be in writing. You will be provided with assistance regarding exercising your rights.

Our responsibilities and requirements: Maintain the privacy of your health information, as required by law; provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; abide by the terms of this Notice; notify you if we cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you; and Accommodate your request for an accounting of disclosures. We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting any of our practice sites and picking up a copy.

To Request Information or File a Complaint - If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the supervisor for your respective treatment site or the Privacy Officer @ 901-747-3630. Additionally, if you believe your privacy rights have been violated, you may file a written complaint with our office by delivering the written complaint to the Privacy Officer @ 8000 Wolf Rvier Blvd. #200, Germantown, Tennessee 38138. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services. [U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, (202) 619-0257 or Toll Free: 877-696-6775 www.hhs.gov/ocr/hipaa/ We cannot, and will not, require you

to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule

Patient Contact: We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may contact you as part of a fund raising effort. If we are unable to reach you by telephone, we will exercise our professional judgment with leaving results of tests and /or procedures on your answering machine. Notification – Opportunity to Agree or Object: Unless you object we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. Communication with Family: If you do not object or in an emergency, using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care. We may use and disclose your protected health information to assist in disaster relief efforts.

Opportunity to Agree or Object Not Required - Public Health Activities Controlling Disease - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. Abuse & Neglect **-** We will disclose protected health information to public authorities as required by law to report abuse or neglect. We may disclose protected health information to governmental authorities to the extent the disclosure is authorized by statue or regulation and if in the exercise of professional judgment, the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victims. Food and Drug Administration (FDA) **-** We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements. Work Related Injury or Illness- With medical surveillance or the evaluation of whether an individual has a work related injury or illness, the organization may disclose protected health information pertaining to a work related injury or illness to the employer if the employer needs the findings i n o rder to comply with OSHA regulations. Oversight Agencies - Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare**.** Judicial / Administrative Proceedings **-** We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process. Law Enforcement - We may disclose your protected health information for law enforcement purposes as required by law; such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury. Coroners, Medical Examiners and Funeral Directors **-** We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties. Organ Procurement Organizations **-** Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant. Research - We may disclose information to researchers when an institutional review board, which has reviewed the research proposal and established protocols to ensure the privacy of your protected health information, has approved their research. Threat to Health and Safety **-** To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public. For Specialized Governmental Functions **-** We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel. Correctional Institutions **-** If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals. Workers Compensation **-** If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation. Other Uses and Disclosures **-** Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Website - We maintain a website that provides information about our entity; this Notice is on the website.