GASTRO HEALTH

Patient Demographic & Insurance Information

Basic Patient Information

Patient's Social Security Number: _____ Date: _____

Name of Patient: _____
First Middle Last

Birth Date: _____ Age: _____ Gender: ❑ F ❑ M
(Must be at least 18 years of age.)

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Email: _____ Employer: _____

Billing Information/Responsible Party/Guarantor for Encounter

Responsible Party: _____
(If Different from Patient) First Middle Last

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Responsible Party's SSN: _____ Gender: ❑ F ❑ M

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Responsible Party's Email: _____ Responsible Party's Employer: _____

Insurance Coverage - Primary

Please present your insurance card & driver's license to the front desk receptionist when returning this form.

Name of Insurance: _____

Policy Number: _____ Effective Date: _____

Group Number: _____ Co-pay Amount: _____

Patient's Relationship to Policyholder: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other

Name of Policyholder: _____ Gender: ❑ F ❑ M
(If Different from Responsible Party) First Middle Last

Birth Date of Policyholder: _____ Phone: ( ) _____
(If Different from Responsible Party)

Name of Policyholder's Employer: _____
(If Different from Responsible Party)

Insurance Coverage - Secondary

Name of Insurance: _____

Policy Number: _____ Effective Date: _____

Group Number: _____ Co-pay Amount: _____

Patient's Relationship to Policyholder: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other

Name of Policyholder: _____ Gender: ❑ F ❑ M
(If Different from Responsible Party) First Middle Last

Birth Date of Policyholder: _____ Phone: ( ) _____
(If Different from Responsible Party)

Name of Policyholder's Employer: _____
(If Different from Responsible Party)

Insurance Coverage - Tertiary

Name of Insurance: _____

Policy Number: _____ Effective Date: _____

Group Number: _____ Co-pay Amount: _____

Patient's Relationship to Policyholder: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other

Name of Policyholder: _____ Gender: ❑ F ❑ M
(If Different from Responsible Party) First Middle Last

Birth Date of Policyholder: _____ Phone: ( ) _____
(If Different from Responsible Party)

Name of Policyholder's Employer: _____
(If Different from Responsible Party)

Additional Patient Information

Primary Care Physician _____

How did you hear about our Practice?

❑ Referred by Another Physician? _____ (Referring Physician's Name)

❑ Friend or Family Member ❑ Facebook ❑ Google/Internet Search ❑ Newspaper/Magazine Ad

Financial Responsibility Agreement

I/We hereby authorize Gastro Health to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If, however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment for medical benefits to Gastro Health and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I/We hereby authorize Gastro Health to act on my behalf in accessing hospital records when and if needed.

_____ _____

Date Patient or Guardian Signature

GASTRO HEALTH

Authorization to Disclose Protected Health Information

Patient Name: _____ **Today's Date:** _____

Patient Phone Number: _____ **Patient Date of Birth:** _____

Any physician, staff, employee or representative of Gastro Health has my permission to disclose my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)

What Information Can be Disclosed? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box.

☐ **All Health Information**	☐ Physician's Orders	☐ Visit Notes	☐ Radiology Reports
☐ History/Physical Exam	☐ Patient Allergies	☐ Discharge Summaries	☐ Imaging Films
☐ Past/Present Medications	☐ Operative Reports	☐ Diagnostic Test Reports	☐ Billing Information
☐ Lab Results	☐ Consultation Reports	☐ Pathology Reports	☐ Other: _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Gastro Health or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature:_____ Date:_____

☐ Copy given to patient

GASTROHEALTH

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Gastro Health:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the PC's Privacy Officer, Mark Johnson at mjohnson@gastrohealth.com or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Patient Signature: _____ Date:_____

GASTRO HEALTH

www.gastrohealth.com

PATIENT INTERVIEW FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date Of Birth: _____

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ Unknown ☐ Patient declines to provide information

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Gender

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ French ☐ Portuguese ☐ Spanish ☐ Creole ☐ Other: _____

PHARMACY

Name _____ Phone Number _____

CURRENT MEDICATIONS

☐ None

Name	Dose	How Taken?

PAST OR PRESENT MEDICAL CONDITIONS

- [ ] None

- [ ] AICD/Pacemaker
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety Disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] Blood Clots
- [ ] Cancer - Breast
- [ ] Cancer - Colon
- [ ] Cancer - Head/Neck
- [ ] Cancer - Leukemia / Lymphoma
- [ ] Cancer - Lung
- [ ] Cancer - Prostate
- [ ] Cancer - Skin
- [ ] Cancer - Other
- [ ] Celiac Disease
- [ ] Chronic Lung Disease
- [ ] Cirrhosis of Liver
- [ ] Colitis
- [ ] Colon Polyps
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diabetes
- [ ] Diverticulitis
- [ ] Endometriosis
- [ ] Fatty Liver
- [ ] Fibromyalgia
- [ ] Gallstones
- [ ] Gastroesophageal RefluxDisease (GERD)
- [ ] Glaucoma
- [ ] Heart Failure
- [ ] Helicobacter Pylori
- [ ] Hemorrhoids
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] High Blood Pressure
- [ ] Hepatitis Other
- [ ] Hernia - Abdominal Wall
- [ ] Hernia - Inguinal
- [ ] High Cholesterol
- [ ] High Triglycerides
- [ ] HIV/AIDS
- [ ] Hernia - Umbilical
- [ ] Irritable Bowel Syndrome
- [ ] Kidney Disease/Failure
- [ ] Kidney Stone
- [ ] Lactose Intolerance
- [ ] Lupus
- [ ] Multiple Sclerosis
- [ ] Myocardial Infarction
- [ ] Osteoporosis
- [ ] Ovarian Cyst
- [ ] Pancreatitis
- [ ] Parkinson's
- [ ] Pneumonia
- [ ] Polio
- [ ] Positive PPD
- [ ] Psoriasis
- [ ] Pulmonary Embolus
- [ ] Rheumatic Fever
- [ ] Seizures
- [ ] Sexually Transmitted Disease
- [ ] Sleep Apnea
- [ ] Stomach / Duodenal Ulcer
- [ ] Stroke
- [ ] TB (Tuberculosis)
- [ ] TB Skin Test (Positive)
- [ ] Thyroid Disease
- [ ] Ulcerative Colitis
- [ ] Uterine Fibroids
- [ ] Other: _____

ALLERGIES

- [ ] Patient has no known allergies
- [ ] Patient has no known drug allergies

- [ ] Aspirin
- [ ] Codeine Sulfate
- [ ] Eggs
- [ ] Iodine/Iodine-Containing Products
- [ ] Morphine
- [ ] Penicillins
- [ ] Sulfa (Sulfonamides)
- [ ] Latex
- [ ] Soy
- [ ] Other: _____

DIAGNOSTIC STUDIES / TESTS

- [ ] None

- [ ] Colonoscopy
  When: _____
- [ ] EGD
  When: _____
- [ ] ERCP
  When: _____
- [ ] Liver Biopsy
  When: _____
- [ ] Enteroscopy
  When: _____
- [ ] EUS
  When: _____
- [ ] Capsule Endoscopy
  When: _____
- [ ] Stress Test
  When: _____
- [ ] Echocardiogram
  When: _____

PREVIOUS PROCEDURES

- [ ] None

- [ ] Abdominoplasty Tummy Tuck
  When: _____
- [ ] Appendectomy
  When: _____
- [ ] Bariatric Surgery - Gastric Banding
  When: _____
- [ ] Bariatric Surgery - Gastric Bypass
  When: _____
- [ ] Bariatric surgery - Gastric Sleeve
  When: _____
- [ ] Bladder Surgery
  When: _____
- [ ] Breast
  When: _____
- [ ] C-Section
  When: _____
- [ ] Colon Resection
  When: _____
- [ ] Colostomy
  When: _____
- [ ] Coronary Bypass Surgery
  When: _____
- [ ] Fundoplication Surgery
  When: _____
- [ ] Gallbladder Surgery
  When: _____
- [ ] Hemorrhoid Surgery
  When: _____
- [ ] Hysterectomy Surgery
  When: _____
- [ ] Inguinal Hernia Repair
  When: _____
- [ ] Ovary Surgery
  When: _____
- [ ] Prostate
  When: _____
- [ ] Stomach
  When: _____
- [ ] Thyroid
  When: _____
- [ ] Tubal Ligation
- [ ] Umbilical Hernia Repair
- [ ] Other _____

FAMILY MEDICAL HISTORY

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Colon Polyps ☐ Liver Disease

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Healthy	☐	☐	☐	☐	☐	☐
Deceased / at Age	_____	_____	_____	_____	_____	_____
Diagnoses						
Alcoholism	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Trouble	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Ulcer Disease	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Occupation: _____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

None

☐ Type	Quantity	Number
☐ Rarely		
☐ Less than 2 days/week		
☐ More than 2 days/week		
☐ I quit using		

Tobacco

Smoking Status ☐ Current daily smoker ☐ Current weekly smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				
☐ Pipe				

Drug Use

☐ None

Type

☐ I have never used recreational drugs ☐ I have used recreational drugs in the past

☐ I am currently using recreational drugs ☐ I have been treated for substance abuse

REVIEW OF SYSTEMS

CONSTITUTIONAL
☐ **None**

Yes	No	
☐	☐	fatigue
☐	☐	fever
☐	☐	weight loss

RESPIRATORY
☐ **None**

Yes	No	
☐	☐	cough
☐	☐	shortness of breath

CARDIOVASCULAR
☐ **None**

Yes	No	
☐	☐	chest pain
☐	☐	palpitations

GASTROINTESTINAL
☐ **None**

Yes	No	
☐	☐	gas
☐	☐	heartburn
☐	☐	nausea
☐	☐	vomiting
☐	☐	trouble swallowing
☐	☐	abdominal pain
☐	☐	change in bowel habits
☐	☐	constipation
☐	☐	diarrhea
☐	☐	soiling/incontinence
☐	☐	rectal bleeding
☐	☐	rectal pain
☐	☐	hemorrhoids
☐	☐	jaundice

HEMATOLOGIC/LYMPHATIC
☐ **None**

Yes	No	
☐	☐	easy bruising/bleeding

GENITOURINARY
☐ **None**

Yes	No	
☐	☐	dark urine

MUSCULOSKELETAL
☐ **None**

Yes	No	
☐	☐	joint pain

INTEGUMENTARY
☐ **None**

Yes	No	
☐	☐	rash

NEUROLOGICAL
☐ **None**

Yes	No	
☐	☐	headaches

PSYCHIATRIC
☐ **None**

Yes	No	
☐	☐	anxiety/depression
☐	☐	memory loss/confusion

IMMUNIZATIONS
☐ None

☐ Flu When: _____
☐ Hepatitis A When: _____
☐ Hepatitis B When: _____
☐ Pneumonia When: _____
☐ HPV When: _____

☐ Shingles When: _____
☐ Tetanus When: _____
☐ Other: When: _____