



specialists in gastroenterology

Notice of Privacy Practices

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.

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.

Examples of Treatment, Payment, and Health Care Operations

Treatment: 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.

Payment: 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.

Health Care Operations: 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.

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.

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.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: 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.

Military and Special Government Functions: 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.

Workers Compensation: 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.

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.

Request Restrictions: 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.

Confidential Communications: 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.

Inspect and Obtain Copies: 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.

Amend Information: 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.

Accounting of Disclosures: 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.

Release of Medical Information

I authorize Specialists in Gastroenterology to use/or disclose certain medical and/or billing information to:

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 detailed information 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: _____

Specialists In Gastroenterology

11525 Olde Cabin Road Creve Coeur, MO 63141 Phone (314) 997-0554 Fax (314) 997-5086

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

NAME: _____
Last First MI

DATE OF BIRTH: ____ - ____ - ____ FORMER NAME: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

I hereby authorize:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

FAX: _____

To disclose my protected health information as indicated below to:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

FAX: _____

INFORMATION TO BE RELEASED:

- Standard Record Release**
Records within the last 2 years
- Any and All Records**
Includes records prior to the past 2 years
- Discharge Summary**
- History & Physical Exam**
- Progress Notes**
- Medication Records**
- Detailed Bill**
- Consult Notes**
- Lab Reports**
- X-Ray Reports**
- Other (specify content and dates):**

I specifically authorize the release of information relating to:

- Substance abuse (i.e. drug/alcohol abuse)
- Mental Health or behavioral health
- HIV related information

x _____
Signature of Patient

PURPOSE OF DISCLOSURE:

- Changing Physicians**
- At request of individual**
- Consultation**
- Continuation of care**
- Other (specify):**

ACKNOWLEDGEMENT OF UNDERSTANDING:

I understand that by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. A photocopy or fax of this authorization is as valid as the original. I may revoke this authorization at any time, except where information has already been release. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulation. I understand that I may see and copy the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it.

PATIENT/LEGAL REPRESENTATIVE SIGNATURE:

DATE: _____



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.

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



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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 Black/African American Asian 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



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Medical History Form

Name: _____ Birth Date: _____ Date: _____

Chief Complaint: (What Brings you in to see the Doctor today?)

For this Problem:

Where is it? _____

When does it occur? _____

How would you describe it? _____

How severe is it? _____

What makes it better or worse? _____

When did it start? _____

How long does it last? _____

What other symptoms do you have?

Did you do anything differently that might have caused you to have these symptoms?

Have you been treated for this condition by someone else? If so, when and what did you have done?

Have you had any lab tests or lab work performed to clarify these symptoms? If yes, what?

Have you had a colonoscopy or endoscopy? If yes, list dates and results.

Social History

What is your Occupation? _____ Full-time or Part-time? _____

Years employed at this job? _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Life Partner _____

Use of Alcohol: Yes _____ No _____ Formally _____

Use of Tobacco: Yes _____ No _____ Former _____

Use of Caffeine: Yes _____ No _____

Are you on any special diet? _____



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Problems List

Name: _____ Birth Date: _____ Date: _____

Medical Conditions:

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Surgeries and Dates:

- | | |
|-----------|-----------|
| 7. _____ | 7. _____ |
| 8. _____ | 8. _____ |
| 9. _____ | 9. _____ |
| 10. _____ | 10. _____ |
| 11. _____ | 11. _____ |
| 12. _____ | 12. _____ |

Medical History (Personal/Family)

Patient's History

Family (Parent, Sibling, Child)

Colon Polyps:	_____	_____
Colon Cancer:	_____	_____
Colitis/Crohn's Disease	_____	_____
Irritable Bowel:	_____	_____
Stomach Ulcer:	_____	_____
Gallstones:	_____	_____
Pancreas Disease:	_____	_____
Diabetes	_____	_____
Breast Cancer:	_____	_____
Uterine Cancer:	_____	_____



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Review of Systems

Name: _____ Birth Date: _____ Date: _____

Gastrointestinal

- Abdominal Pain
- Change in Bowel Habits
- Constipation
- Diarrhea
- Difficulty Swallowing
- Reflux
- Heartburn
- Blood in Stool
- Black Stool
- Loss of Appetite
- Vomiting
- Vomiting Blood
- Nausea
- History of Hepatitis
- Bloating
- Gas
- Barrett's Esophagus
- Crohn's Disease
- Ulcerative Colitis
- Irritable Bowel
- Enlarged Belly after Eating

Neurological

- Dizziness
- Headache
- Numbness
- Tremors
- Vertigo
- Fatigue
- Sleep Disorder
- Stroke or Seizure
- Restless Legs Syndrome

Urologic

- Painful Urination
- Blood in Urine
- Urinary Frequency
- Urinary Incontinence
- Urinary Retention
- Renal Failure
- Kidney Stones
- Pelvic Pain
- Interstitial Cystitis

Psychological

- Anxiety
- Depression
- Increased Stress

Reproductive

- Penile/Vaginal Discharge
- Sexual Dysfunction
- Breast Lumps
- Breast Pain

Eyes

- Double Vision
- Eye Pain
- Iritis or Uveitis
- Blurred Vision
- Glaucoma

Ears, Nose, Throat

- Ear Infections
- Nasal Congestion
- Sinus Infection
- Sore Throat
- Mouth Sores
- Bleeding Gums
- Bad Breath
- Bad Taste
- Hoarseness

Cardiovascular

- Chest Pain
- Swelling of Legs and Ankles
- Irregular Heart Beat
- High Blood Pressure
- Heart Attack (Year _____)
- Congestive Heart Failure
- Chest Pain with Exertion
- Have you had a Stress Test?
- Rheumatic Fever
- Coronary Bypass/Stenting
- Heart Valve Replacement
- Pacemaker

Respiratory

- Shortness of Breath
- Frequent Cough
- Chest Pain
- Wheezing
- Asthma
- Emphysema
- Sleep Apnea

Skin

- Contact Allergy
- Hives
- Itching
- Rash
- Change in Skin Color
- Change in hair or nails

Constitutional

- Chills
- Fever
- General Discomfort
- Weight Loss

Endocrine

- Cold Intolerance
- Heat Intolerance
- Excessive Thirst
- Diabetes
- Thyroid Disease
- Excessive Thirst or Urination
- Change in hat or glove size

Hematological

- Easy Bleeding
- Easy Bruising
- Swollen Lymph Nodes
- Slow to heal after cuts
- Anemia

Muscle and Joints

- Back Pain
- Muscle Pain
- Joint Pain
- Swelling or Stiffness
- Weakness of Muscles
- Fibromyalgia