Digestive Disease Specialist

◯ Dr. Fernandez ◯ Dr. Pugliese ◯ Dr. Tummala

Patient Information

Patient Name (Last, First, Middle): _____ *DOB:* _____

Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Home Phone: _____ *Cell Phone:* _____ *Social Security Number:* _____

Race: _____ *Sex:* _____ *Marital Status:* _____ *Preferred Language:* _____

Email: _____ *Employer:* _____ *Phone:* _____

Primary Care Physician: _____ *Phone:* _____

Pharmacy: _____ *Location:* _____ *Phone:* _____

Insurance Information

Primary Insurance: _____ *Contract Number:* _____ *Group Number:* _____

Name of Insured on Card: _____ *Relationship:* _____ *Birthdate:* _____

Secondary Insurance: _____ *Contract Number:* _____ *Group Number:* _____

Name of Insured on Card: _____ *Relationship:* _____ *Birthdate:* _____

Responsible Party

Name (Last, First, Middle): _____ *DOB:* _____

Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Home Phone: _____ *Cell Phone:* _____

Emergency Contact

Name (Last, First, Middle): _____ *Relationship:* _____ *Cell Phone:* _____

I understand and agree that (regardless of my insurance status), I am responsible for the balance of my account for any professional services rendered. Should collection proceedings become necessary, I agree to pay all cost of collection including a reasonable attorney's fee and do hereby waive all rights to claim personal property except under the laws and constitution of the state of Alabama. I certify the above information is true and correct to the best of my knowledge. I will notify Digestive Disease Specialist of any changes in my health status or change of the above information.

Signature of Patient/Legal Guardian: _____ Date _____

Digestive Disease Specialists of Northeast Alabama

Patient's Name: _____ Date of Birth: _____

Referring Physician: _____ Age: _____

Primary Care Physician: _____

Chief Complaint: _____

Current Symptoms:

__ Headaches	__ Hoarseness	__ Chest Pain	__ Palpitations	__ Chronic Cough
__ Abdominal Pain	__ Heartburn	__ Indigestion	__ Nausea	__ Vomiting
__ Difficulty Swallowing	__ Appetite Loss	__ Weight Loss	__ Vomiting Blood	__ Blood in stool
__ Diarrhea	__ Constipation	__ Yellow skin	__ Gas	__ Bloating

Prescription & Over the Counter Medications:

Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____
Name: _____	Dosage: _____	Frequency: _____

Gastrointestinal Medical History: (Mark all conditions YOU have had.)

__ Celiac Disease or Sprue	__ Hiatal Hernia	__ Hemorrhoids	__ **Gastrointestinal Bleeding**
__ Colon Polyps	__ Diverticulosis/Diverticulitis	__ GERD/ Acid reflux	__ Alcohol Abuse
__ Yellow skin/ Jaundice	__ Hepatitis	__ Crohn's Disease	__ Ulcerative Colitis
__ Stomach Ulcer	__ Esophageal Stricture	__ Helicobacter Pylori	__ Anal Fissure
__ Bowel Obstruction	__ Irritable Bowel Syndrome	__ Barrett's Esophagus	__ Chronic Diarrhea
__ Chronic Constipation	__ Pancreatitis	__ Liver Cirrhosis	

__ Other: _____

__ Most Recent Egd (list date and physician): _____

__ Most Recent Colonoscopy (list date and physician): _____

__ Most Recent ERCP (list date and physician): _____

__ Most Recent CT (list date and location): _____

__ Most Recent Ultrasound (list date and location): _____

__ Most Recent Laboratory Work (list date and location): _____

Non-Gastrointestinal Medical History:

__ Congestive Heart Failure	__ Kidney Disease	__ Asthma	__ Lupus
__ Diabetes	__ Multiple Sclerosis	__ Arthritis	__ Glaucoma
__ Fibromyalgia	__ Sleep Apnea	__ Stroke	__ Blood Clots
__ Bleeding Disorder	__ Palpitations	__ High Cholesterol	__ Heart Disease
__ Heart Attack	__ Anemia	__ HIV/AIDS	__ Hypertension
__ Emphysema	__ COPD	__ Anxiety	__ Depression

Other: _____

Cancer History:

__ Esophageal	__ Liver	__ Lungs	__ Uterine	__ Breast
__ Ovarian	__ Mouth/Throat	__ Colon/Rectal	__ Blood	__ Skin
__ Stomach	__ Prostate	__ Pancreatic	__ Other: _____	

Drug and Food Allergies: _____

__ Anaphylactic or Other Reaction to Anesthesia __ Contrast or Iodine Allergy __ Latex Allergy

Surgical History:

__ Lysis of Adhesions
__ Brain Surgery
__ Colon Resection
__ Coronary Bypass
__ Heart Valve Replacement
__ C-section
__ Hip Replacement
__ Pacemaker Placement
__ Appendectomy
__ Breast Augmentation
__ Mastectomy
__ Liver Transplant
__ Knee Replacement
__ Cardiac Defibrillator
__ Cholecystectomy (Gallbladder)
__ Hiatal Hernia Surgery
__ Cardiac Stent
__ Shoulder Surgery
__ Tonsillectomy
__ Stomach Resection
__ Prostate Surgery
__ Kidney Surgery
__ Gastric Bypass/Lapband
__ Back Surgery
__ Other: _____

Family History: __ Unknown __ Adopted

Family Member:	Alive / Deceased / Unknown:	History of Colon Cancer:	Medical History:
Mother	Alive / Deceased / Unknown	Yes / No	
Father	Alive / Deceased / Unknown	Yes / No	
Spouse	Alive / Deceased / Unknown	Yes / No	
Paternal Grandfather	Alive / Deceased / Unknown	Yes / No	
Paternal Grandmother	Alive / Deceased / Unknown	Yes / No	
Maternal Grandfather	Alive / Deceased / Unknown	Yes / No	
Maternal Grandmother	Alive / Deceased / Unknown	Yes / No	

Personal & Social History:

(1) Do you have history of OR currently use tobacco? _____ If so, what kind and how often? _____

(2) Do you have history of OR currently use IV drugs or other recreational drugs? _____ If so, what kind and how often? _____

(3) Do you have history of OR currently consume alcohol? _____ If so, what kind and how often? _____

(4) Do you have tattoos? _____ If so, were they done by a professional? _____

(5) Do you have history of a blood transfusion? _____ If so, what year? _____

Digestive Disease Specialist

HIPPA

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I _____ am giving the following people permission to access my medical information including, but not limited to, lab reports, financial records, and office visits.

1. (Name)_____ (Phone) _____ (Relationship) _____
2. (Name)_____ (Phone) _____ (Relationship) _____
3. (Name)_____ (Phone) _____ (Relationship) _____
4. (Name)_____ (Phone) _____ (Relationship) _____
5. (Name)_____ (Phone) _____ (Relationship) _____

If you do not wish to disclose any medical information to anyone other than yourself please initial here. _____

This authorization remains in effect until I give written notification to discontinue.

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Digestive Disease Specialists of Northeast Alabama

900 Goodyear Ave Ste A Gadsden Al 35903

Ph: 256-492-3220 Fax: 256-492-3366

Authorization to Use or Disclose Protected Health Information

Patient Name (Last, First, Middle):_____

Patient Date of Birth:_____

I authorize the use/disclose of health information about me as described below:

(1)Person or class of persons authorized to use/disclose/receive information:

All hospitals and physicians unless otherwise noted.

(2)Desciption of information that may be used/disclosed/received:

All hospitals and physicians unless otherwise noted.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information use/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by contacting or sending such written notification to the office manager of Digestive Disease Specialists except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 3 years.

Print Patient's Name:_____ Date:_____

Signature of Patient:_____

Signature of Parent (if patient is a minor):_____

NOTICE OF PRIVACY PRACTICES

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

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at Digestive Disease Specialists of NE Alabama may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Digestive Disease Specialists of NE Alabama or the hospital. For example, we may disclose medical information about you to people outside Digestive Disease Specialists of NE Alabama who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Digestive Disease Specialists of NE Alabama and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Digestive Disease Specialists of NE Alabama personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes Digestive Disease Specialists of NE Alabama policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Digestive Disease Specialists of NE Alabama personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at Digestive Disease Specialists of NE Alabama. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Digestive Disease Specialists of NE Alabama, whether made by Digestive Disease Specialists of NE Alabama personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, Digestive Disease Specialists of NE Alabama. To request an ameadment, your request must be made in writing and submitted to Lisia Carrizales, Privacy Officer at Digestive Disease Specialists of NE Alabama and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Lisia Carrizales, Privacy Officer at Digestive Disease Specialists of NE Alabama.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from Digestive Disease Specialists of NE Alabama . Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to Lisia Carrizales, Privacy Officer at Digestive Disease Specialists of NE Alabama. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Digestive Disease Specialists of NE Alabama waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with Digestive Disease Specialists of NE Alabama or with the Secretary of the Department of Health and Human Services. To file a complaint with Digestive Disease Specialists of NE Alabama, contact Lisia Carrizales, Privacy Officer, 256-492-3220,900 Goodyear Avenue, Suite A, Gadsden, AL 35903. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact Lisia Carrizales, Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**