**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT INSTRUCTIONS**

Please Complete Sections 1& 2 And Sign All Other Forms Including Medication List.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION 1** | | | | | | | | |
| Patient’s Name: | | | | | | Age: | DOB | |
| Address: | | | | | | | | |
| Home  Phone: | | Cell  Phone: | | Work  Phone: | | | Preferred Contact:  ○ Home ○ Cell ○ Work | |
|  | Email: | | SSN: | | | | Preferred  Pharmacy: | |
|  | Emergency Contact  Name: | | Emergency Contact  Phone Number: | | | | | Relationship  To Patient: |
|  | Marital Status:  ○ Single ○ Married ○ Partnered ○ Divorced ○ Separated ○ Widowed | | | | | | | |
|  | Gender:  ○ Male ○ Female | | | If Female, Date of Last Menstrual Period: | | | | |
|  | Referring Provider: | | | Phone Number: | | | | |
|  | Primary Care Provider: | | | Phone Number: | | | | |
|  | Any Known Allergies or Adverse Drug Reactions? ○ No ○ Yes If Yes, List Them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  | What Is the Reason for Your GI Appointment Today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
|  | Have You Ever Had A Colonoscopy? ○ No ○ Yes If Yes Please Provide the Date, Location and Results of The Procedure:    Date: Facility: Results: | | | | | | | |
|  | Have You Ever Had an Upper GI Endoscopy (EGD)? ○ No ○ Yes If Yes Please Provide the Date, Location and Results of The Procedure:  Date: Facility: Results: | | | | | | | |
|  | **SURGICAL HISTORY** | | | | | | | |
|  | Date Surgery/Operation Hospital | | | | Date Surgery/Operation Hospital | | | |
|  | **HOSPITALIZATION HISTORY** | | | | | | | |
|  | Date Reason Hospital | | | | Date Reason Hospital | | | |
|  | **HISTORY OF HEALTH SYMPTOMS**  (Please Check All Symptoms That Apply) | | | | | | | |
|  | ○ Change in Appetite ○ Chills ○ Fatigue ○ Fever ○ Night Sweats ○Weigh Loss ○ Nausea ○Vomiting ○Abdominal Pain ○ Bloating  ○ Indigestion ○ Blood in Stool ○ Hemorrhoids ○ Black Stool ○ Rectal Bleeding ○Belching ○ Heartburn ○Change in Bowel Habits ○ Hernias | | | | | | | |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **SECTION 2** |
| **PERSONAL HISTORY**  Are You Sexually Active? **○** No **○** Yes If Yes, Is there any history of sexually transmitted diseases? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do You Have Any Children? **○** No **○** Yes Have You Traveled Outside of The U.S. In the Last 6 Months? **○** No **○** Yes |
| **PERSONAL HEALTH HISTORY**  (Please Check All That Apply) |
| **○** Hypertension **○** Liver Disease **○** Pancreatitis **○** Stomach Ulcer **○** Colon Cancer  **○** Diabetes **○** Lung Disease **○** Crohn’s Disease **○** Ulcerative Colitis **○** Esophageal Cancer  **○** Heart Disease **○** Kidney Disease **○** Acid Reflux/Heartburn **○** Irritable Bowel Syndrome **○** Stomach Cancer |
| **HEALTH HABITS** |
| Have You Ever Had A Blood Transfusion? ○ Yes ○ No Do You Have Any Tattoos or Body Piercings? ○ Yes ○ No  **ALCOHOL**  Do You **Currently** Drink Alcohol? ○ Yes ○ No If Yes, How Long Have You Been Drinking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  On Average, How Many Servings Do You Consume Per Day/Week?  Beer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Liquor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If No, Did You Drink Alcohol **in The Past**? ○ Yes ○ No How Long Ago Did You Quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **TOBACCO**  Do You **Currently** Use Tobacco? ○ Yes ○ No If Yes, How Long Have You Used Tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  On Average, How Much Do You Smoke Per Day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Light Cigarette Smoker (1-9 cigs/day) Moderate Cigarette Smoker (10-19 cigs/day) Heavy Cigarette Smoker (20-39 cigs/day)  If No, Did You Use Tobacco in The Past? ○ Yes ○ No If Yes, How Long Ago Did You Quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **RECREATIONAL/STREET DRUGS**  (Cocaine, Marijuana,Heroin, Methamphetamine, etc.)  Have You Ever Injected Drugs with A Needle? ○ Yes ○ No Have You Ever Inhaled Drugs Through Your Nose? ○ Yes ○ No  Do You **Currently** Use Recreational/Street Drugs? ○ Yes ○ No Did You Use Recreational/Street Drugs **in The Past**? ○ Yes ○ No  If Yes, Which Drugs? If Yes, Which Drugs? |
| **MENTAL HEALTH** |
| Do You/Have You Suffered from Depression? ○ Yes ○ No Do You/Have You Suffered from Anxiety? ○ Yes ○ No  If Yes, Please Explain: If Yes, Please Explain: |
| **FAMILY HEALTH HISTORY** |
| Has Anyone in Your Family Had Colon Cancer? ○ Yes ○ No Has Anyone in Your Family Had Colon Polyps? ○ Yes ○ No  List Any Significant Medical Problems Your Parents, Siblings, Children Have Had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS**

Please List **ALL** Your Prescriptions, Inhalers, Topicals, Birth Control, Over-The-Counter Meds & Herbal Supplements.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication Name** | | **Dose** | **Dosing Schedule** | **Start Date** | **Stop Date** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**PLEASE READ AND SIGN**

I request that payment of authorized health plan benefits be made on my behalf to Oasis Advanced Gastroenterology, Inc. for any services furnished by that physician/facility/supplier. I also authorize the release of any medical information necessary to process my claim. I realize that any insurance payments that may be received on my account may not represent full payment for services and that I am responsible for the balance due on my account. Additionally, if I fail to show up for an appointment (without 24-hour notice), I may be charged a cancellation fee of $35. I also acknowledge that the medication list written above is the most updated list available.

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS**

I hereby authorize **OASIS ADVANCED GASTROENTEROLOGY INC.** to obtain any and all medical records concerning my care from any physician, hospital, nursing facility or other healthcare professional that has provided medical care to me in the past. I also authorize the practice to release any and all medical records concerning my care to any physician, hospital, nursing facility, or other healthcare professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to Medicare, Medicaid, IEHP and any other insurance company, third-party administrator, or managed care company.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature Date Signed**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name Date of Birth**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

In accordance with the federal government’s privacy rule implementation of the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of **OASIS ADVANCED GASTROENTEROLOGY INC. (OAG)** to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

\_\_\_\_\_\_\_\_\_\_\_ I **DO NOT** authorize OAG to release any and all information concerning my medical care to any individual except as set forth below.

\_\_\_\_\_\_\_\_\_\_\_ I **Authorize** OAG to verbally release any or all information concerning my medical care to the following individual (s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (s) Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date Signed

**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.**

This notice of Privacy Practices describes how we may use and disclose your protected health information to carryout treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. “Protected health information” is information about you, including demographic information that may identify you, and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

**Uses and Disclosure of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay any healthcare bills, to support the operation of the physician’s practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. Your protected health information may be provided to a physician to whom you’ve been referred to, to ensure that the physician has necessary information to diagnose or treat you in regards to the continuity of your care.

**Payment:** Your Protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for the hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign you name and indicate the physician you are to be seeing. We may also call you by name in the waiting room when you are ready to be seen by the physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, Workers’ Compensation, and inmates. Required uses and disclosures: under the law, we must make disclosures to you and when requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Patient Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of you protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in, for notification purposes, as described in this notice of privacy practices. You must state the specific restriction requested and to whom you want the restrictions to apply towards.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.

**You have the right to request to receive confidential communications from OAG by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively, i.e. electronically.

**You have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures OAG have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to OAG or to the Secretary of Health and Human Services if you believe your privacy right have been violated. You may file a complaint with us by notifying our privacy contact. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/ or before August 1, 2017.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to your protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

**Signature below is only acknowledgement that you have received this notice of our privacy practices.**

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_