GASTROENTEROLOGY ASSOCIATES OF BROOKLYN

Contact Information

Today's Date:

Patient Name (Please print)	Date of Birth	Last 4 digits of SS#

Race: ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ White Non-Hispanic ☐ Other: ____________

Street Address	Apt. #	City, State and Zip Code

Email Address	Home Telephone#	Cellular #	Work # (if ok to call)

Please list method of contact in order of preference

Contact Information

Primary Insurance	Policy#
Secondary Insurance	**Policy#**

Primary insurance holder (if not yourself)	Date of Birth	Social Security Number

Do you have prescription coverage with insurance? ☐ Yes ☐ No

Pharmacy Information

Name	Address	Phone#

Emergency Information

Primary contact	Relationship	Telephone#
Secondary contact	**Relationship**	**Telephone#**

Your Gastroenterologist	Tel#
Primary Care Physician	**Tel#**

I attest that the above information provided by me is accurate

Signature of Patient

Date

Signature of Legal Guardian, Health Care Proxy, or Power of Attorney

Date

Welcome to our office! It is our pleasure and privilege to act as your health care provider. Please answer the following questions to the best of your ability so that we may better attend to your health care needs. All information will be kept confidential.

Medical History

Please let us know why you came to our office

Have you had a Colonoscopy in the past? ☐ Yes ☐ No

If Yes, when was the last one, and were any polyps or malignancy found? __________

Have you had any recent (in the past 1 year) or past problems with

	Recent	Past	No		Recent	Past	No
Diabetes	☐	☐	☐	Ulcers	☐	☐	☐
High blood pressure	☐	☐	☐	Liver Disease	☐	☐	☐
Heart attack	☐	☐	☐	Heartburn/Acid Reflux	☐	☐	☐
Cardiac stents	☐	☐	☐	Gallstones	☐	☐	☐
Pacemaker	☐	☐	☐	Blood clots	☐	☐	☐
Abnormal heart rhythm	☐	☐	☐	Osteoporosis	☐	☐	☐
	☐	☐	☐	Chronic lung disease	☐	☐	☐

Please list any medical conditions, hospitalizations and surgeries (other than cancer) starting with the most recent, and the approximate year. You will have an opportunity to list cancers separately on the next page:

Do you smoke?

☐ Yes If yes, how many years have you been a smoker? __________ How many packs per day? _____

☐ No If no, were you ever a smoker? ☐ Yes ☐ No If you smoked in the past, when did you quit? __________

Do you drink alcohol?

☐ Yes If so, what type of alcohol do you drink? __________ How many drinks per day? _____

☐ No

I am: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

With whom do you live?

What is/was your occupation?

Are you retired? ☐ Yes ☐ No

Cancer History

Personal history of cancer (YOURSELF) ☐ Yes ☐ No

	At what age, and how was it treated?
☐ Colon Cancer	
☐ Colonic Polyps	
☐ Stomach Cancer	
☐ Pancreatic Cancer	
☐ Liver Cancer	
☐ Ovarian Cancer	
☐ Breast Cancer	
☐ Prostate Cancer	
☐	

Family History of Cancer (BLOOD RELATIVES) ☐ Yes ☐ No

	Which relative, and at what age?
☐ Colon Cancer	
☐ Colonic Polyps	
☐ Stomach Cancer	
☐ Pancreatic Cancer	
☐ Liver Cancer	
☐ Ovarian Cancer	
☐ Breast Cancer	
☐ Prostate Cancer	
☐	

Your Preferences

☑ Do you give permission to discuss medical or financial information with anyone else (ex. family member/friend)? ☐ Yes ☐ No

If yes, whom? ____________________

☑ Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No

(If yes, this will be honored at any hospital).

☑ Do you have a Health Care Proxy? ☐ Yes ☐ No

If yes, whom? ____________________

☑ Are there any Religious, Cultural, or Personal Beliefs that may preclude you from receiving advanced medical treatment, blood, blood products, etc.? ☐ Yes ☐ No

If yes, explain: ____________________

I attest that the above information provided by me is accurate:

____________________ ____________
Signature of Patient Date

____________________ ____________
Signature of Legal Guardian, Health Care Proxy, or Power of Attorney Date

For future visits only: I have reviewed the information previously supplied and it is unchanged from my last visit.

____________________ ____________
Signature of Patient Date

____________________ ____________
Signature of Legal Guardian, Health Care Proxy, or Power of Attorney Date

GASTROENTEROLOGY ASSOCIATES OF BROOKLYN

To Be Completed When Payment in Full is Not Rendered at the Time of Service

It is the policy of the BayRidge Gastroenterology (BRG) to require payment in full for all services at the time such services are rendered. In order to induce BRG to defer collection from me pending the initial processing of an insurance claim to be submitted to my insurance company ("Insurance"), I hereby agree as follows:

I accept and acknowledge full financial responsibility for all co-payments, deductibles, and fees associated with my treatment. I also accept and acknowledge full financial responsibility for all services provided to the extent not actually and timely paid to BRG by my Insurance.

I will take all actions and execute all documents necessary to assure that any payment to which I am entitled from my Insurance with respect to services provided by BRG doctors will be paid directly to BRG. If my Insurance makes payment directly to me or to my insured family member, I (and my insured family member when applicable, jointly) acknowledge that I (we) are responsible to immediately forward such payment and copies of any and all accompanying explanations of benefits to BRG.

I also acknowledge and agree that in the event that the co-payments and deductibles, as well as non covered services, (the "outstanding billings") are not paid at the time of the office visit and or procedure, these outstanding bills will begin to accumulate interest commencing 30 days after demand for payment, or 15 days after notification to BRG that my Insurance has made payment directly to me or my insured family member, whichever is earlier, at the monthly rate of 1.5%, simple interest (annual percentage rate ("APR") of 18%) and which interest will be added on to any unpaid balance. In the event that I or my insured family member receives direct payment from my Insurance, I will cause such payment to be immediately turned over to BRG. I further acknowledge that I (and my insured family member where applicable) will also be responsible for any costs and fees BRG may incur in enforcing this Agreement, which includes any and all reasonable attorney's fees which BRG may incur. I understand that I am free to consult with an attorney before signing this or any agreement.

Any dispute regarding the meaning and enforcement of this Agreement will be determined under New York law, without regard to conflicts of law principles, and will be exclusively resolved in a court of competent jurisdiction located in or having jurisdiction over Brooklyn, New York, and I hereby irrevocably submit to the personal jurisdiction of such court for purposes of enforcing this agreement.

Patient Signature ______________________ Date ______________

Insured Signature ______________________ Date ______________

Patient Name (PRINT) ______________________

Insured Name (PRINT) ______________________

Relationship to Patient (PRINT) ______________________

GASTROENTEROLOGY
ASSOCIATES OF BROOKLYN

I, ____, acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions to the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Signature

____
Date

GASTROENTEROLOGY ASSOCIATES OF BROOKLYN

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

We are required by law (Health Insurance Portability and Accountability Act of 1996-HIPAA) to maintain the privacy of your health information; and to abide by the terms of the Notice that are currently in effect.

PERMITTED USES AND DISCLOSURES OF YOUR INFORMATION

We may use or disclose your health information for purposes of treatment, payment and healthcare operations.

For Treatment: We will use and disclose your health information in providing you with treatment and services and in coordinating your care with other healthcare professionals involved in your care.

For payment: We may use and disclose your health information for billing and payment purposes. We may disclose your health information to your representative, or to and insurance managed care company, Medicare, Medicaid or another third party payer.

For Health Care Operations: we may use and disclose your health information as necessary for operations, such as management, personnel evaluation, education and training and to monitor our quality of care. We may disclose your information to another entity with which we have a relationship to provide patient or business services on our or your behalf.

SPECIFIC USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following lists various ways in which we may disclose your health information without your consent or authorization.

Individuals Involved in Your Care or Payment of Your Care unless you object, we may disclose health information about you to a person you identify such as a family member or close personal friend.

Emergencies: As Required by Law or Public Health Activities

Appointment Reminders or Treatment Alternatives and Health-Related Benefits and Services: We will make every effort to insure your confidentiality and contact you in the manner you prefer.

Business Associates: We may disclose your protected health information to a contractor or business associate who needs the information to perform services. Our business associates are committed to preserving the confidentiality of this information.

Reporting Victims of Abuse, Neglect or Domestic Violence: If we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your health information to notify a government authority if authorized by law or you agree to the report.

Health Oversight: Activities We may disclose your health information to an oversight agency for activities authorized by law such as audits, investigations, licensure actions and government oversight activities of the health care system.

To Avert a Serious Threat to the Health or Safety to You, to Another Person, to the Public or to Minimize a Threat

Judicial and Administrative Proceedings: We may disclose your health information in response to a court or administrative order in response to a subpoena, discovery request or lawful process; efforts must be made to contact you about the request or to obtain and order or agreement protecting the information.

Law Enforcement, Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations, Disaster Relief Organizations

Military, Veterans and Other Specific Government Authorities and Inmates/Law Enforcement Custody

Workers Compensation

USES AND DISCLOSURE WITH YOUR AUTHORIZATION

Except as described in this Notice, we will disclose your health information only with your written Authorization. You may revoke an Authorization in writing at any time. If you revoke an Authorization, we will no longer use or disclose your health information for the authorized purposes, except where we have already relied on the Authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Listed below are your rights regarding your health information. Each of these rights is subject to certain requirements, limitations and exceptions. Exercise of these tights may require submitting a request in writing. You have the right to:

Request Restrictions on our use or disclosure of your health information for treatment, payment or healthcare operations, restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment of your care. We are not required to agree to your restriction and, if we do not agree to accept, we will comply with your request except as needed to provide you emergency treatment.

Request Amendment: You have the right to request amendment of your medical record. Your request must be made in writing and must specify the reason for the requested amendment. We may deny your request if we have reason to believe that the original information is accurate and must supply you with denial in writing.

Request a Copy of this Notice: You have the right to obtain a paper copy of this Notice. You may request a copy of this notice at any time. Please contact our office or ask for a copy at the reception desk.

Request an Accounting of Uses and Disclosures: You have the right to request an accounting of the disclosures of your personal health information that is used or disclosed for other that treatment, payment or healthcare operations. All requests must be made in writing and pertain to information disclosed after April 14,2003. One request will be provided to you at no charge. Additional requests made within twelve-month period may be subject to a fee.

Request Confidential Communications: You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

SPECIAL RULES REGARDING DISCLOSURE OF PSYCHIATRIC, SUBSTANCE ABUSE AND HIV-RELATED INFORMATION

For disclosures concerning health information relating to care for psychiatric, substance abuse or HIV testing and treatment, except as permitted or required under state or federal law, health information may not be disclosed without your special authorization unless for treatment or payment purposes.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make effective our new Notice provisions for all health information already received maintained as well as for all health information obtained in the future. We will provide a copy of the revised Notice upon implementation.

FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact our privacy officer at 718.745.0623. If you believe your privacy has been violated or would like to file a complaint, please send a written notification to our officer at 9920 4TH Avenue, Suite 205, Brooklyn, N.Y. 11209, ATTN: Privacy Officer. Please include the patient's name and address, a detailed description of the circumstances surrounding the complaint, your signature, the date, and contact information. If you are not satisfied with our response you may notify the Office of Civil Rights int the U.S. Department of Health and Human Services.

Effective Date: April 14, 2003

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.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you receive at the practice 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 the practice or the hospital. For example, we may disclose medical information about you to people outside the practice 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 the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice 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 our practice's policies and procedures and that of any heath 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 practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. 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 the practice, whether made by practice 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 your legal duties and privacy practices with respect to medical information about you; and to follow the forms 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; protective services for the President and others; 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 AN ACCOUNTING OF DISCLOSURES: You have the right to request and "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 the Privacy Officer.

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, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

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 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 REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you about medical matters in a certain way or at certain location. You must make your request in writing and you must specify how or there you wish to be contacted.

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 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 the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. 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 our Privacy Officer I acknowledge by signing below that I have received the **Notice of Privacy Practices and Notice of Individual Rights**.