GASTROENTEROLOGY CONSULTANTS, P.C.

Patient Name (LAST):_____ (FIRST)_____ (MI)_____

Address:_____ City:_____ Zip:_____

Telephone Number: ( )_____Date of Birth:_____

Work contact phone number ( ) _____ Cell phone ( ) _____

E-mail address (optional) _____ Circle one: MALE FEMALE

Marital Status: ___Married ___Single ___Widowed ___Divorced ___Partnered

Patient Employer:_____ Telephone: ( )_____

If Minor, List Parent or Guardian Name:_____

Person (not living with you) to call in case of emergency_____Phone ( )_____

Spouse Name:_____ Spouse Date of Birth: ___

Address: _____ Phone ( ) _____

Primary Insurance Co. (*Please list both name and address*):_____

_____

Policy Holder Name:_____ ID#:_____ Grp#:_____

Secondary Insurance Co. *(Please list both name and address)*:_____

_____

Policy Holder Name:_____ ID#:_____ Grp#:_____

Referring Physician:_____Telephone ( )_____

Primary Care Physician:_____Telephone ( )_____

INSURANCE AUTHORIZATION/ASSIGNMENT:

I hereby authorize **Gastroenterology Consultants, P.C.** to release necessary information to insurance carriers acquired in the course of my treatment.

Signature:_____ Date:_____

I hereby assign payment of medical benefits for me or my dependent(s) to **Gastroenterology Consultants, P.C.**

Signature:_____ Date:_____

Gastroenterology Consultants, P.C.

Specialists in Digestive and Liver Diseases

Alan M. Fixelle, M.D., F.A.C.G.
Eugene H. Hirsh, M.D., F.A.C.G.

NOTICE OF PRIVACY PRACTICES

This notice applies to **Gastroenterology Consultants P.C. ("GC")** and all of its subsidiaries. This Notice describes how medical information about you may be used and disclosed and you can get access to this information. **Please review it carefully.** You have the right to obtain a paper copy of this Notice upon request.

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 or may be participating in your treatment, to pharmacists or pharmacy personnel who are filling your prescriptions and to family members, significant other, health aid (s) or surrogates 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 via phone, fax, email, postcard or letter. 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 or 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 death 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 may 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.

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 Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in your records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Contact Person. You may mail in your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

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 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 Office Manager at this location.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the Office Manager at the location of your GC physician. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Effective Date: December 1, 2006

I_____, hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed_____

Date_____

Relation to patient_____

Gastroenterology Consultants, P.C.

Specialists in Digestive and Liver Diseases

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Eugene H. Hirsh, M.D., F.A.C.G.

OFFICE & FINANCIAL POLICIES

Please read our office & financial policies completely. Please initial each item to attest that you have read and accept the terms. If you have any questions or concerns, please direct them to our Office Manager.

____ I understand that I will be asked to provide my insurance card and picture ID ***at each visit***.
(Our office requires positive identification at every visit for your protection)

____ I understand that it is ***my responsibility*** to understand the rules and terms of my insurance. Gastroenterology Consultants accepts and files my insurance as a courtesy and if insurance has not made payment within 90 days the balance will be my responsibility. (We **will not** explain coverage, benefits, or guarantee our participation status in your plan. You need to obtain this information from your insurance carrier via telephone, Internet, or the human resources representative of your employer prior to your visit).

____ I understand that I am expected to pay co-payments and estimates of unsatisfied deductibles ***at the time of service.*** I will be asked to reschedule my appointment if I cannot pay at this time.

____ I understand that your office accepts cash, check, and most credit cards. I will be charged a $40 service fee for returned checks.

____ I understand that laboratory, pathology, and Anesthesiology bills are separate from our services. All inquiries about these outside invoices must be directed to the service provider or my insurance carrier.

____ I understand that any unpaid balance on my account(s) will be referred to an outside collection agency that will report to the credit bureau and/or resort to further legal action and additional collection fees will be added to my account.

____ I understand that prescription refills are only authorized during ***regular office hours*** and I should allow 24-48 hours for completion. Additional time may be needed if my prescription requires a prior authorization.

____ I understand that when calling the office for scheduling, medical questions/test results, billing information and/or prescription refills I may get a voicemail and when leaving a message I must provide my name, date of birth, callback number and allow up to 24 hours for a return call. I understand making multiple calls and leaving multiple messages may delay the response.

____ I understand that when making appointments for office visits or procedures that if I ***MUST*** reschedule or cancel my appointment that I ***MUST*** give a 24 hour notice. All cancelations with less than 24 hours notice or missed appointments will be charged $75 for office visits and $250 for procedures. I understand that I may be charged a deposit of $200 to reschedule a missed appointment or for appointments that have been rescheduled more than 3 times.

_____ _____

Patient signature Date

Thank you for your cooperation.

PATIENT HEALTH HISTORY FORM

To our patients: Welcome to our practice. Please take your time to complete this form.
If you have any questions, please ask for assistance. Thank you.

GASTROENTEROLOGY CONSULTANTS, P.C.

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL/NAME _____

Who referred you to our office? _____ **TODAY'S DATE:** _____

Please list any other physicians involved in your care: _____

DATE OF BIRTH: _____ **PLACE OF BIRTH:** _____ **OCCUPATION** _____

MARITAL STATUS: ___Single ___Married ___Separated ___Widow/Widower ___Divorced ___Partnered

REASON FOR VISIT: Please describe the problem which prompted your visit? _____

_____

_____

Please list any lab tests, procedures or X-ray/radiology studies performed (e.g. by another physician or ER visit), that may relate to your current problem: _____

MEDICATIONS: Please list all prescribed **OR over-the-counter** medications/supplements (including vitamins and herbal compounds) prescribed or taken recently. **Please include the dose and frequency for each item listed.**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DO YOU TAKE: Aspirin? [ ] YES [ ] NO Anti-inflammatory pain medications (e.g. *Motrin, Advil*, etc.)? [ ] YES [ ] NO

ALLERGIES TO MEDICATIONS:

_____

OTHER ALLERGIES: _____

Any problems with iodine or intravenous contrast (dye)? [ ] YES [ ] NO Novocaine? [ ] YES [ ] NO

Have you ever experienced any problems with anesthesia? [ ] YES [ ] NO Explanation: _____

SURGICAL HISTORY: Please list **ANY** operations/surgical procedures performed in the past?

YEAR	TYPE OF SURGERY	SURGEON/HOSPITAL (If known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS: Please list any medical illnesses that required hospitalization (other than for surgery or childbirth)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DATE OF LAST COLONOSCOPY: _____ **or [ ]** Never **REASON FOR EXAM:** _____

PHYSICIAN WHO PERFORMED EXAM: _____ **FINDINGS:** _____

Name:_____ **Date of Birth:** _____

Other major medical illnesses or problems not included above:

_____

_____

_____

_____

_____

FAMILY HISTORY:

Any member of your **family** (including parents, grandparents, siblings and children) ever had the following?

Illnesses affecting **OTHER** family members	Relationship to you?	How old when diagnosed?
Colon polyps or cancer of the colon		
Breast cancer		
Cancer – other type (describe part of body affected)		
Ulcer disease		
Liver diseases (cirrhosis, hepatitis, etc.)		
Inflammatory bowel disease (Crohn's or ulcerative colitis)		
Gallbladder disease or prior gallbladder surgery		
Hypertension/high blood pressure		
Heart disease		
Diabetes		
Mental / psychiatric disorder(anxiety, depression, suicide, etc.)		
Drug or alcohol addiction		
Bleeding tendency		
Obesity		

Any other important illness(es) _____

YOUR PERSONAL HABITS:

Smoking: Do you **now, or have you ever** been a smoker? ..... **[ ] YES** **[ ] NO, I NEVER SMOKED**

Average use (estimate): _____ packs each day for approximately _____ years

If you are a **former** smoker, when did you stop? _____.

Alcohol: Do you drink any alcoholic beverages? ..... **[ ] YES** **[ ] NO**

Quantity? (please **estimate** the **average** amount) : _____ mixed drinks _____ glasses of wine _____ beer

How often do you drink this amount? (*circle* one answer) **per** DAY / WEEK / MONTH / YEAR

Have you ever been told or thought that you were an alcoholic? ..... **[ ] YES** **[ ] NO**

Drugs: Have you **ever** (EVEN ONCE) used a needle/syringe to inject street drugs? ..... **[ ] YES** **[ ] NO**

Do you now or have you ever used other illicit, illegal or "recreational" drugs? ..... **[ ] YES** **[ ] NO**

Please explain: _____

CLINICAL NOTES [FOR OFFICE USE ONLY]:

Name:_____ **Date of Birth:** _____

REVIEW OF SYSTEMS: These are some general health questions– please indicate with an **X** or [***check mark***] if **YOU** have currently or in the past experienced (*to a significant degree*) the following problems. Please provide details as appropriate.

CONSTITUTIONAL:

____ Significant change in appetite? ……

____ Have you had any **recent** weight change?……

_____ lbs [ ] Loss [ ] Gain Since when? _____

____ Recent fever? ……

____ Night sweats? ……

SKIN DISORDERS:

____ Eczema? ……

____ Hives? ……

____ Rash requiring treatment? ……

____ Unexplained itching? ……

____ Skin cancer? ……

HEAD-EYES-EARS-MOUTH-NOSE:

____ Any serious head injury? ……

____ Difficulty seeing? ……

____ Eyeglasses or contact lenses?……

____ Cataracts or glaucoma……

____ Any hearing loss? ……

____ Loss of smell? ……

____ Mouth sores? ……

CARDIOVASCULAR:

____ High blood pressure? ……

____ A racing heart/palpitations? ……

____ Chest pains or tightness with exertion (walking/ climbing)? ……

____ Waking up at night short of breath? ……

____ Swollen feet or ankles? ……

____ Leg cramps or leg discomfort with walking? ……

____ Heart murmur? ……

____ Artificial heart valve? ……

____ Any infection of a heart valve? ……

____ Heart attack? ……

____ Pacemaker? ……

RESPIRATORY:

____ Wheezing or asthma? ……

____ Coughing up a lot of phlegm (sputum)……

____ Coughing up blood? ……

____ Chronic bronchitis? ……

____ Emphysema? ……

____ Tuberculosis? ……

____ Awakened at night with coughing or choking?……

GASTROINTESTINAL:

____ Hepatitis (liver infection) Type A, B or C or jaundice? ……

____ Cirrhosis (scarring of the liver)? ……

____ Other liver problem or abnormal liver tests? ……

____ Disease of the pancreas (including pancreatitis)? ……

____ Gallbladder problems/stones? ……

____ Problems swallowing food? ……

____ Heartburn or indigestion? ……

____ Bloating? ……

____ Abdominal pain? ……

____ Recent changes in bowel movements? ……

____ Frequent use of laxatives or enemas?……

____ Black or tarry bowel movements? ……

____ Blood in your stools/bowel movements? ……

____ Colon polyps? ……

____ Stomach/duodenal ulcers? ……

____ Vomiting blood? ……

____ Milk / lactose intolerance? ……

PSYCHIATRIC:

____Hospitalized for nervous breakdown? ……

____Tension/Anxiety/Depressive Disorder? ……

____ Bipolar Disorder? ……

____ Schizophrenia? ……

____ Ever attempted suicide or serious thoughts about suicide? …

ENDOCRINE:

____ Thyroid disease? ……

____ Diabetes requiring insulin? ……

____ Diabetes requiring pills/diet? ……

____ Any unusual sweating? ……

____ Calcium or bone problems? ……

HEMATOPOIETIC/LYMPHATIC:

____ Anemia or history of anemia?

____ Blood transfusions **EVER** in the past……

When? _____

____ Tendency to bleed easily when cut? ……

____ Blood clotting disorder? ……

____ Are you known to be HIV (AIDS antibody positive)? ……

____ Swelling of any lymph glands? ……

Name: _____Date of Birth:_____

MUSCULOSKELETAL:

_____ Back pain (as a frequent or serious/continuing problem)? ……

_____ Muscle weakness or muscle disease? ……

_____ Arthritis? ……

_____ Stiff or painful muscles or joints? ……

_____ Joints ever swollen? ……

When was your last bone density test (for osteoporosis)? _____

Was it normal? YES NO _____

GENITOURINARY:

_____ Kidney disease? ……

_____ Kidney stones or past history of kidney stones? ……

_____ Painful or difficult urination? ……

_____ Blood in your urine? ……

(***FOR MEN ONLY):***

_____ Weak or very slow urine stream? ……

_____ Prostate trouble? ……

_____ Discharge from your penis? ……

_____ Swelling or lumps in your testicles? ……

_____ Painful testicles? ……

NEUROLOGICAL:

_____ Epilepsy or seizures?……

_____ Stroke? ……

_____ Frequent or severe headaches? ……

_____ Dizziness or blackout spells?……

GYNECOLOGIC (*FOR WOMEN ONLY*):

When was your last menstrual period?_____ Was it normal? YES NO

When was your last PAP smear?_____ Was it normal? YES NO

When was your last mammogram?_____ Was it normal? YES NO

Pregnancies : Total # pregnancies _____

____Births; ____ Miscarriages; ___ Abortions

_____ Excessive bleeding with your periods? ……

_____ Bleeding between your periods? ……

_____ Lumps in your breasts? ……

_____ Cancer in the female organs? ……

_____ **Do you think you may be pregnant?**

If there are any other medical problems or questions you would like to address with the physician or staff, please use the space below to record your information:

This information will be kept in your chart, and may be easily updated in the future.
We welcome any comments or suggestions that might improve the quality of your visit.
Thank you for your cooperation.

Reviewed by _____ DATE _____

Gastroenterology Consultants, P.C.
Specialists in Digestive and Liver Diseases

Alan M. Fixelle, M.D., F.A.C.G.
Eugene H. Hirsh, M.D., F.A.C.G.

CONSENT FOR TREATMENT

You agree to permit your protected health information to be used and disclosed for purposes of treatment, payment, and health care operations. For more details about these uses and disclosures, please see our Privacy Notice.

We reserve the right to change our privacy policies described in the Privacy Notice. You may call us to receive an updated Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree with this request, but if we do, we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use or disclosure of your information.

_____ _____

Signature Date

Gastroenterology Consultants, P.C.

Specialists in Digestive and Liver Diseases

Alan M. Fixelle, M.D., F.A.C.G.
Eugene H. Hirsh, M.D., F.A.C.G.

DATE: _____

TO: _____

_____

_____

Patient Name: _____

Date of Birth: _____

Our practice is presently providing medical services to the above named patient. Please submit copies of any **clinical notes, discharge summaries, operative notes, laboratory, pathology and/or radiology reports** on file in your office. Thank you for your prompt assistance.

Alan M. Fixelle, M.D. **Eugene H. Hirsh, M.D.**

MEDICAL RECORDS RELEASE AUTHORIZATION

I,_____, Date of Birth_____ authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I understand that this information is of a confidential nature and that the insurance carrier may review these documents.

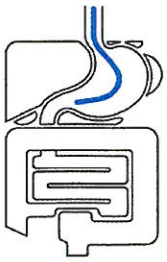
_____ _____

Signature of Person Giving Consent Date

Relationship [if not patient]: _____

Patient unable to sign due to: _____

This document expires one year from the date signed.



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Patient Agreement for Communications

I, _____, understand that as part of my health care Gastroenterology Consultants, P.C. will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Gastroenterology Consultants, P.C. to contact me in the following ways:

_____ Home Phone (voice mail) Number: _____
_____ Office Phone (voice mail) Number: _____
_____ Cell Phone (voice mail) Number: _____
_____ Fax Number: _____
_____ Cell Phone (Text) Number: _____
_____ Cell Phone (Email) Email address: _____

I authorize Gastroenterology Consultants, P.C. to speak with the following person/s and release information on my behalf:

_____
_____
_____

I understand that Gastroenterology Consultants, P.C. will convey the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already completed.

_____
Date

_____
Print Name

_____
Signature of Patient or Authorized Party

_____
Relationship to Patient