GASTROENTEROLOGY CONSULTANTS, P.C.

M. Thomas Riddick, M.D. Melvin Bullock, M.D.
11685 Alpharetta Hwy., Ste 320
Roswell, GA 30076
(770) 442-5882 Fax (770) 754-9749

Last Name _____First Name_____M.I._____

Address _____Apt. No. _____ City_____

State_____Zip_____ Date of Birth:_____ Sex (M/F) _____

Preferred Phone( )_____Home ( ) _____ Cell ( )_____

Social Security Number_____ E-mail Address: _____
Race (please circle): Asian African Am. Hispanic White Refuse Other
Marital Status: S M W D

Patient's Employer_____Phone Number( )_____
Employment Status: (Circle one) Full-time Part-time Unemployed Retired Self-Employed

Spouse's Name_____
Spouse's Employer_____Phone_____

Insurance Information: Insured Name_____
(if different than patient) Insured Date of Birth_____
Insured SS#_____
Person to contact in case of Emergency_____Phone_____
Who is your Primary Care Physician?_____Phone_____
Name of Physician Referring you to our practice_____

Insurance Information: I acknowledge that M. Thomas Riddick, M.D. or Melvin Bullock, M.D. may or may not be a part of my provider network for my insurance company and that it is my responsibility to verify that my doctor is on my plan. All professional services rendered are charged to the patient. We will file your insurance as a courtesy; however, the patient is responsible for all fees regardless of insurance coverage.

I hereby authorize Gastroenterology Consultants to furnish all information to my insurance carrier concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Date_____Signature_____

IMPORTANT NOTICE

IT IS POSSIBLE THAT YOUR TREATMENT WILL INCLUDE AN OUTPATIENT PROCEDURE. PLEASE BE AWARE THAT THERE WILL BE CHARGES SEPARATE FROM DR. RIDDICK'S/ DR. BULLOCK'S FEE. I.E., FACILITY, ANESTHESIA, PATHOLOGY.

IF YOU HAVE A PROCEDURE THAT IS SCHEDULED AT GEORGIA ENDOSCOPY CENTER THAT NEEDS TO BE CANCELLED, A 2-DAY NOTICE IS REQUIRED. IF THE APPROPRIATE NOTICE IS NOT RECEIVED, A FEE OF $250.00 CAN BE CHARGED TO THE PATIENT. INSURANCE COMPANIES WILL NOT COVER THIS FEE.

THERE MAY ALSO BE TIMES WHEN OUR DOCTOR ORDERS TESTING OUTSIDE OF OUR OFFICE, WHICH MAY INCLUDE BLOOD WORK, X-RAYS, ETC. THESE CHARGES ARE NOT PART OF THE OFFICE VISIT AND YOUR REGULAR BENEFITS WILL APPLY.

IF YOU ARE HERE FOR A CONSULTATION VISIT PRIOR TO SCHEDULING A COLONOSCOPY, PLEASE BE ADVISED THAT THIS IS CONSIDERED A SPECIALIST OFFICE VISIT AND NOT CONSIDERED PREVENTATIVE. YOUR USUAL BENEFITS WILL APPLY AS WITH ANY OTHER SPECIALIST OFFICE VISIT. IT IS NOT CONSIDERED PART OF THE COLONOSCOPY PROCEDURE.

IF YOUR INSURANCE REQUIRES A REFERRAL TO OUR OFFICE, IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN. IF A PROCEDURE YOU HAVE SCHEDULED NEEDS TO HAVE PRECERTIFICATION, OUR OFFICE WILL OBTAIN THIS FROM YOUR INSURANCE COMPANY.

IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHAT HIS/HER INSURANCE BENEFITS ARE AND WHAT THEY WILL OR WILL NOT COVER.

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE.

_____

Patient Printed Name **Date**

_____

PATIENT'S SIGNATURE **Date**

Gastroenterology Consultants, P.C.
2016 HIPAA Authorization Form

I , _____, authorize the following individuals to have full access to my health information:

Name:_____ Relationship:_____Date:_____

Name:_____ Relationship: _____Date: _____

I,_____give my permission for you to leave any medical/lab information for me at the following phone numbers:

Home # _____
Cell # _____
Work # _____

Signed_____Date_____

PATIENT MEDICAL QUESTIONAIRE

Have you ever had a Colonoscopy? _____YES _____NO
If so, when?_____

(Females)
Have you ever had a Mammogram? _____YES _____NO
If so, when ?_____

Have you ever had a Bone Density Study? _____YES ____ NO
If so, when? _____

Have you ever had a Pneumovax Vaccine(for Pneumonia)? ____YES ____NO
If so, when? _____

Please list all current medications:

_____
_____
_____
_____
_____
_____
_____

Medicine Allergies :_____
_____

Please provide a pharmacy that you may use:

Pharmacy_____
Address_____City_____
Phone number_____

My preferred method of contact from our office is:

____Phone ____E-mail ____Postal Mail

Signed_____Date_____

GASTROENTEROLOGY CONSULTANTS, P.C.

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 Health and Human Services. You will not be penalized in any way for filing a complaint.

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

Signed_____

Date_____