PATIENT REGISTRATION

Account # :____________________________ Drivers License Verified : ❑ Yes ❑ No

Today's Date :____________________________

Primary Provider ❑ Kamionkowski ❑ Lissauer ❑ Frankel ❑ Kirsh ❑ Gellis ❑ McNally ❑ Longbons

PATIENT INFORMATION

Last Name _____________________________________ Social Security # __ __ __ - __ __ - __ __ __ __

First Name _____________________________________ Middle Initial _____

Birthdate _____ / _____ / ________ E-mail Address ______________________________

Address _______________________________________ Apartment/Suite # ___________________________

City ____ State _________ Zip _______________

Home Phone ( ) __ __ __ -- __ __ __ __ ❑ Male ❑ Female Age ________

Cell Phone ( ) __ __ __ -- __ __ __ _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Employer ____ Occupation ____

Address ____ Work Phone ( ) __ __ __ -- __ __ __ __

City ____ State _____ Zip ____________

POLICY HOLDER INFORMATION (IF DIFFERENT THAN PATIENT)

Name ____

Address _______________________________________ Apartment/Suite # _________________________

City ____ State _________ Zip _______________

Home Phone ( ) __ __ __ -- __ __ __ __ Relationship_____________________________________

Employer _______________________________________ Occupation ___________________________________

Address ____ Work Phone ( ) __ __ __ -- __ __ __ __

City ____ State _____ Zip _____________________

Social Security _________________________ Birthdate: ______/______/___________

REFERRING or PRIMARY CARE PHYSICIAN

Your Physicians Name ____

How were you referred to the office? ❑ Website ❑ Internet Search ❑ Yellow/White Pages ❑ Family Member ❑ Friend ❑ Physician

EMERGENCY INFORMATION

EmergencyContact ____

Address ____

City ____ State ______ Zip____________

Phone ( ) __ __ __ -- __ __ __ __ Relationship _________________________

Allergies: ____

Current Medication: ____

Do you take: ❑ Aspirin ❑ Blood Thinner (Lovenox, Heparin, Coumadin, Plavix, Persanthine, Vitamin E)

FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO TREAT

1. AUTHORIZATION OF TREATMENT AND RELEASE OF MEDICAL INFORMATION

A. Permission for Treatment

I, the undersigned patient or patient's legal guardian, acknowledge that the physicians of Gastroenterology Associates of Cleveland, Inc., its employees and other healthcare professionals assigned to patient's care are authorized to administer any treatment as may be deemed necessary or advisable for the diagnosis and treatment of the patient. I understand that this care may include examinations, tests and medical treatment.

B. Release of Medical Information by Gastroenterology Associates of Cleveland, Inc.

The undersigned patient or patient's legal guardian hereby authorizes Gastroenterology Associates of Cleveland, Inc. to release any medical information (including information regarding substance abuse, HIV, and psychiatric treatment) requested by third-party payers, including but not limited to those indicated on the attached photocopy, or their reviewing agencies, to enable payment of insurance proceeds and/or other healthcare benefits for the care rendered by Gastroenterology Associates of Cleveland, Inc. I also authorize the release of such medical information to patient's non-Gastroenterology Associates of Cleveland, Inc. doctors for medical treatment and follow-up. This authorization is subject to written revocation at any time except to the extent that action has been taken in reliance hereon and shall in any event expire one-year following the date hereof. I hereby release Gastroenterology Associates of Cleveland, Inc. from all legal responsibility or liability relating to the release, disclosure and examination of confidential medical

C. Release of Medical Information to Gastroenterology Associates of Cleveland, Inc.

The undersigned patient or patient's legal guardian hereby authorizes the release and disclosure by any healthcare provider or holder of medical information about the patient of any medical information (including information regarding substances abuse, HIV, and psychiatric treatment) pertaining to patient to Gastroenterology Associates of Cleveland, Inc. in connection with patient's medical care and treatment. This authorization is subject to written revocation at any time except to the extent that action has been taken in reliance hereon and shall in any event expire one year following the date hereof.

2. FINANCIAL RESPONSIBILITY FOR HEALTHCARE SERVICES

A. Financial Policy

As the patient or patient's legal guardian, you are reminded that healthcare services rendered to the patient by physicians and/or staff of Gastroenterology Associates of Cleveland, Inc. is charged to the patient and, generally, you are responsible for payment in full for such services. It is your responsibility to understand any health insurance policy or healthcare plan which covers the patient for all or any part of such services.

If under the patient's health insurance policy or healthcare plan, the patient has designated a primary care physician ("PCP"), the patient is required to have prior authorization from such PCP to be seen and treated by a physician of Gastroenterology Associates of Cleveland, Inc. If this authorization is not provided, you will be asked to either reschedule the patient's appointment or pay in full for the visit and treatment at the time such services are rendered.

All co-payment amounts which are the patient's responsibility under the applicable health policy or plan generally are due and payable at the time of service. All other amounts are due within 60 days thereafter, unless other arrangements have been made with and agreed to in writing by Gastroenterology Associates of Cleveland, Inc., which generally does not accept monthly payments unless a written payment agreement is on file in its accounting office. This should allow sufficient time to process coverage under applicable health insurance and healthcare plans and to make payment in full of any remaining balance. Extensions to this policy may be granted for those patients whose primary health insurance carrier is Medicare, a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), which makes payment directly to Gastroenterology Associates of Cleveland, Inc. for its services. Gastroenterology Associates of Cleveland, Inc. will assist you in completing the necessary health insurance or healthcare claims forms to seek appropriate payment with respect to the services performed. In the event of duplicate payments by the insurance carrier or plan administrator, the overpayment will be refunded to you.

B. Assignment of Healthcare Benefits

The undersigned patient or patient's legal guardian hereby assigns to Gastroenterology Associates of Cleveland, Inc., as its interests may appear, all healthcare benefits to which the patient is entitled under the provisions of any and all health insurance policies and/or healthcare plans providing coverage to the patient by virtue of any and all services rendered by physicians and/or staff of Gastroenterology Associates of Cleveland, Inc. during this visit and/or subsequent visits. The undersigned further directs such insurer(s) and/or plan administrators and fiduciaries to pay such benefits on behalf of the patient directly to Gastroenterology Associates of Cleveland, Inc.

Additionally, the undersigned authorizes that payment of any Medicare benefits to which the patient is entitled with respect to services furnished to patient by Gastroenterology Associates of Cleveland, Inc. be made on patient's behalf to Gastroenterology Associates of Cleveland, Inc. and hereby further authorizes any holder of medical information about the patient to release to the Centers for Medicare and Medicaid Services ("CMS") and its agents any information needed to determine such benefits or the benefits payable for related services.

C. Guaranty of Payment

In consideration of all clinical, professional and endoscopic services rendered and/or to be rendered to the patient whose name appears below and at the request of patient or patient's legal guardian, the undersigned, as guarantor (i.e., the personal responsible for payment), unconditionally guarantees payment in full to Gastroenterology Associates of Cleveland, Inc. of any and all of its charges for such services without limitation as to time or amount and acknowledges that all co-payment amounts relating to such services are due and payable at the time of service with any balance due within 90 days thereafter, unless other arrangements have been made with and agreed to in writing by Gastroenterology Associates of Cleveland, Inc. In the event Caresource does not pay due to charges being denied as Workers Compensation, I gurantee payment on those denied charges.

Authorization of Treatment, Release of Medical Information and Assignment of Healthcare Benefits

By signing below, I have reviewed, understand and consent to Sections I, II A & B and C of this form. A copy of my signature is as valid as the original.

Name of Patient ______________________________Guarantor's Signature ____________________________________ Date ___________________________

Witness Name ________________________________Witness Signature ____Date ________________________

Patient Received Copy of Financial Policy on _______________ Employee Initials _______

Gastroenterology Associates of Cleveland, Inc.

New Patient Gastrointestinal / Medical History Form

Please fill out this form completely and bring it with you on your first visit. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*	☐ **M** ☐ **F**	**Date of Birth**:
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered		
Previous or Referring Doctor:	Date of Last Physical Exam:	

PERSONAL HEALTH HISTORY

Adult Immunizations and Dates:	☐ Tetanus Booster	☐ Influenza
	☐ Hepatitis A	☐ Hepatitis B

HEALTH HABITS AND PERSONAL SAFETY

Caffeine:	☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? ______
Chocolate:	☐ None ☐ 2 - 3x Daily ☐ 2 – 3 x Week
Alcohol:	Do you drink alcohol? .... ☐ Yes ☐ No If yes, what kind? ☐ wine, ☐ beer, ☐ whiskey How many drinks per week? _____
Tobacco:	Do you use tobacco? .... ☐ Yes ☐ No ☐ Cigarettes - Packs/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____ ☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

GASTROINTESTINAL HISTORY

☐	Poor Appetite	☐	Rectal Bleeding	☐	Wheezing or Asthma
☐	Nausea/Vomiting	☐	Black Bowel Movements	☐	Milk or Lactose Intolerance/Wheat Allergy
☐	Vomiting Blood	☐	Abdominal Discomfort/Pain	☐	Colon Polyps in the Past
☐	Frequent Heartburn	☐	Belching	☐	Colon Cancer in the Past
☐	Heartburn Awakens	☐	Bloating	☐	Liver Disease or Jaundice
☐	Trouble Swallowing	☐	Diarrhea	☐	Hepatitis A
☐	History of ulcers	☐	Constipation	☐	Hepatitis B or C
☐	Hiatal Hernia	☐	Bowel Habit is Unpredictable	☐	Gallstones
☐	Chronic Cough	☐	Lost Bowel Control or Soiling	☐	Unexplained Weight Loss
☐	Persistent Hoarseness	☐	Passing a lot of gas/flatus	☐	Frequent/Recent Travel out of the Country
☐	Food sticks with swallowing	☐	Frequent Sore Throat	☐	Diverticulitis or Diverticulosis

GENERAL REVIEW OF SYSTEMS

General		Throat/Teeth and Gums		**Kidneys/Urinary System**	
☐	Weight Loss or Gain	☐	Sore tongue	☐	Frequency of urination
☐	Fatigue	☐	Dry mouth	☐	Urgent need to urinate
☐	Fever or Shaking Chills	☐	Dentures	☐	Difficulty starting urination
☐	Night Sweats	☐	Non-healing sores	☐	Burning or pain on urination
☐	Trouble Sleeping	☐	Bleeding gums	☐	Blood in urine
☐	Weakness	**Neck**		☐	Change in Urinary Stream
Skin		☐	Lumps	☐	Dribbling after urination
☐	Rashes/Change in moles	☐	Swollen glands	☐	Constant loss of urine
☐	Itching	☐	Pain	☐	With cough/sneeze do you lose urine
☐	Dryness	☐	Stiffness		
☐	Color changes	**Respiratory/Lungs**		**Vascular**	
Ears		☐	Cough either dry or wet	☐	Calf pain when walking
☐	Decreased hearing	☐	Sputum	☐	Leg cramping/swelling
☐	Ringing in the ears	☐	Coughing up blood	**Musculoskeletal**	
Eyes		☐	Cough either dry or wet	☐	Muscle or joint pain

☐	Redness	☐	Wheezing	☐	Stiffness of joints
☐	Blurry or double vision	☐	Painful breathing	☐	Back pain
☐	Flashing lights	**Cardiovascular**		☐	Traumatic injury
☐	Cataracts	☐	Chest pain or discomfort	**Hematologic**	
☐	Pain	☐	Heart Murmur	☐	Easy bruising
Nose		☐	Mitral Valve Prolapse	☐	Bleeding for prolonged periods of time
☐	Stuffiness	☐	Swelling of legs or ankles	☐	Were you ever told that you are anemic
☐	Nasal discharge	☐	High Blood Pressure	**(Notes)**	
☐	Nose bleeds	☐	High Cholesterol		
☐	Sinus pain/problems	☐	Shortness of breath with activity		
☐	Drainage in back of throat	☐	Heart Attack in the Past		
		☐	Irregular Heart Beat		
Neurologic		**Endocrine**			
☐	Dizziness	☐	Heat or cold intolerance		
☐	Fainting	☐	Sweating		
☐	Seizures	☐	Frequent urination		
☐	Weakness in arms or legs	☐	Constant thirst		
☐	Numbness or Tingling	☐	Change in appetite		
☐	Shaking or Tremor	☐	Thin hair		

ALLERGY HISTORY

☐		☐	Iodine or Shellfish	☐	Hay Fever

Please list other allergies or drug reactions:

MEDICATION HISTORY

(Please list all medications, either prescription or over the counter, vitamins, herbal preparations, nutritional products)

	Medication	Dose	Number of times taken each day
1			
2			
3			
4			
5			
6			
7			
8			

MEDICAL PROBLEMS / HOSPITALIZATIONS / SURGERIES

Please check off or list all medical conditions for which you are currently being treated. (ex. high blood pressure)

☐	Hip or Knee Replacement	1	
☐	Heart Valve Replacement	2	
☐	Internal Cardiac Defibrillator (ICD)	3	
☐	Heart Pacemaker	4	
☐	Electronic Urinary Devices	5	
☐	Neurologic (Nerve) Stimulators	6	
☐	Port-a-Cath	7	
☐	PICC Line	8	
If you have the information card for the device, please bring it with you		9	
		10	

FAMILY HISTORY			
	Age	**Medical Problems**	**Deceased**
Father			☐
Mother			☐
Brother/Sister			☐
Brother/Sister			☐
Brother/Sister			☐
Brother/Sister			☐
Child			☐
Child			☐
Child			☐

MENTAL HEALTH

Is stress a major problem for you? .... ☐ Yes ☐ No
Do you feel depressed? .... ☐ Yes ☐ No
Do you panic when stressed? .... ☐ Yes ☐ No
Do you have problems with eating or your appetite? .... ☐ Yes ☐ No
Do you cry frequently? .... ☐ Yes ☐ No
Do you have trouble sleeping? .... ☐ Yes ☐ No

PLEASE EXPLAIN IN YOUR OWN WORDS WHY YOU ARE HERE TODAY.

Patient Signature ____ Today's Date_____________

ADDITIONAL NOTES	
Body System	

Reviewed at time of interview/examination by:

Physician/PA/NP ____ Date: ________________

Gastroenterology Associates of Cleveland, Inc.

Consent to the Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Gastroenterology Associates of Cleveland, Inc. or disclosed to others for the purposes of treatment, obtaining payment, to comply with legal mandates, or to support the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Gastroenterology Associates of Cleveland, Inc. may or may not agree to restrict the use or disclosure of your protected health information.

If Gastroenterology Associates of Cleveland, Inc. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Gastroenterology Associates of Cleveland, Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Gastroenterology Associates of Cleveland, Inc. to use and disclosure my health information in accordance with it.

____ ____________________________________

Name of Patient (Print or Type) Signature of Patient

____

Signature of Patient Representative

____ __________________________________

Relationship of Patient Representative to Patient Date of Signature

Gastroenterology Associates of Cleveland, Inc.

Standard Authorization of Use and Disclosure of Protected Health Information

An authorized representative is a person you authorize to act on your behalf, in obtaining your Protected Health Information ("PHI") on your behalf, in pursing a claim or an appeal of a denied claim. This authorization may be either (1) granted for a particular event or date of service, after which time the authorization approval is revoked, or (2) granted indefinitely.

Information to Be Used or Disclosed

The information covered by this authorization includes:

____

____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

____
Name of person/organization

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

____
Name of person/organization

Expiration Date of Authorization

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **Gastroenterology Associates of Cleveland, Inc.** You should contact our Privacy Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____ _____________________________________
Signature of Patient Representative Relationship to Patient

Notice of Privacy Practices

Gastroenterology Associates of Cleveland, Incorporate (GAC) presents this Notice to our patients describing how your medical information may be used or disclosed and how 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
GAC uses health information about you for treatment, analyzing procedures and lab results. We use information to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances where the law applies, we may be required to use or disclose the information without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: GAC 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 medical record and use it to determine the most appropriate course of care. GAC may also disclose this information by fax, in person, or via telecommunication. We may communicate to other health care providers who are participating in your treatment, to pharmacists who are filling and refilling your prescriptions, and to family members who are helping with your care.

Payment: GAC will use and disclose your health information for payment purposes. For example, GAC may need to obtain authorization from your insurance company before providing certain types of treatment. GAC will submit bills and maintain records of payments from your health plan.

Health Care Operations: GAC 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.

Release of Information to Family or Friends
GAC knows that family or friends are an integral part of a patient's care. If you wish to authorize a family member or friend to speak with us regarding your care or test results, please write their name and contact information on the 'Notice of Privacy Practices Acknowledgement' form. GAC will not release your information to any friend or family without your written consent.

Special Uses
GAC may use your information to contact you with appointment reminders by phone or mail. GAC may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. This communication may be sent to you via the methods listed above. If you have granted written permission, the above information may also be sent to you via email. If you wish to authorize the use of email as a method for GAC to communicate with you, sign the proper section on the 'Notice of Privacy Practices Acknowledgement' form.

Other Uses and Disclosures
GAC may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, GAC is permitted to give out health information without your permission for the following purposes:

- **Required by Law:** GAC may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

- **Research:** GAC may use or disclose information for approved medical research.
- **Public Health Activities:** As required by law, GAC may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- **Health Oversight:** GAC may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- **Judicial and Administrative Proceedings:** GAC may disclose information in response to an appropriate subpoena or court order.
- **Law Enforcement Purposes:** Subject to certain restrictions, GAC may disclose information required by law enforcement officials.
- **Deaths:** We may report information regarding deaths to coroners, medical examiners, funeral and organ donation agencies.
- **Serious Threat to Health or Safety:** GAC 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, GAC may release information as required by military command authorities. GAC may also disclose information to correctional institutions or for national security purposes.
- **Workers' Compensation:** GAC may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will 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. Submit any concerns in writing to GAC's compliance officer (see below).

- **Request Restrictions:** You may request restrictions on certain uses and disclosures of your health information. GAC is not required to agree to such restrictions, but if we do agree, GAC must abide by those restrictions.
- **Confidential Communications:** You may ask us to communicate with you confidentially. Please ask to see the practice administrator to initiate and document this request.
- **Inspect and Obtain Copies:** You have the right to see or receive a copy of your health information. There may be a small charge dictated by Ohio Law for these copies.
- **Amend Information:** If you believe information in your record is incorrect, you have the right to request that GAC correct or amend the existing information. Your GAC physician has the right to refuse your request. Regardless, a letter concerning your request will be sent within 30 days of said request.
- **Accounting of 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. A current version of our Notice is available in each waiting area at all times. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below

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 person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

For additional information, please contact:

Gastroenterology Associates of Cleveland, Incorporated
Attn: Privacy Officer
3700 Park East Drive, STE 100
Beachwood, Ohio 44122