Dear Patient,

We are pleased that you chose the physicians of Gastro One for your gastrointestinal medical care.

To prepare for this procedure it is important that you go to the following areas of our website www.gastro1.com:

Under the “For Your Visit” tab please select the “Colonoscopy Information Video” link located on the right hand side of the screen. The video must be watched prior to your procedure. The procedure will not be done if the informed consent video has not been watched.

Continue on to the “What To Do Before Your Visit” section and select the following:

1. Register for the “Patient Portal” by selecting the link in paragraph #1.

2. Complete the additional “Insurance and Consent forms” by selecting the link in paragraph #2 and printing off the forms.

3. Please complete the “Anesthesia Pre-Registration” on our partner site Simple Admit by selecting the link in paragraph #3. The information requested on this site is for our Anesthesia team to review prior to your procedure. The password to initially log on is “Gastro1”.

4. Proceed to the Colonoscopy Prep Instruction section to download and review the “Full Procedure Information Booklet”.

5. The Prep Instructions are also available for download if you misplace your paper copies.

Following the instructions to prepare you for your procedure is of the utmost importance. If you have any questions after you review the information please call our Open Access Department at 901-522-6630.

Sincerely,

The Open Access Team & The Physicians of Gastro One
You have been scheduled for an endoscopic exam.

*It is very important that you read the enclosed information and instructions several days prior to your appointment.*
Please read all the instructions carefully several days prior to your procedure.

1. Please ARRIVE at the Endoscopy Center at _______________AM/PM on _______________(date).

   You should plan to be in the Center between 2 and 3 hours. The length of time you are in the Center is based on a variety of things, such as the condition of your prep, what is found during your procedure, additional treatments performed by your physician, and an adequate amount of time for your recovery. Please be assured each patient will be given his/her appropriate amount of time regardless of the Center’s schedule.

   1310 Wolf Park Drive
   Germantown, TN 38138
   (901) 624-5151

   8000 Wolf River Blvd.
   Suite 105
   Germantown, TN 38138
   (901) 747-3630

   7668 Airways Blvd.
   Bldg. B
   Southaven, MS 38671
   (662) 349-6950
   (901) 766-9490

2. Carefully follow the instructions regarding food and drink limitations in order to have your procedure.

3. Have your adult driver stay in the Endoscopy Center.

   If you are having a colonoscopy, make sure you obtain the prep medications several days prior to your procedure. If you have questions regarding your prep instructions, please contact your physician’s office.

   It is very important that you complete your Simple Admit registration several days prior to your procedure. A link to their website can be found on the www.gastro1.com website under Procedure Pre-Registration. The user password is Gastro1. If you do not have access to a computer please call 1-877-848-4726 and they will assist you.

   If you have any questions during your prep, please call your physician’s office, or the physician on call.
1. Bring an adult driver. Your driver must be 18 years of age or over and they must stay in the Endoscopy Center. You will be given a sedative for your test and you are not to drive until the next day. Therefore, one person must stay and drive you home. Your procedure will be rescheduled if your driver cannot stay in the Center.

2. If you need to reschedule your procedure, please call your physician’s office at least 3-4 days in advance so that we may schedule another patient in your appointment time.

3. Notify us in advance if you are taking a blood thinner prescribed by a physician (such as Coumadin, Plavix, Effient, Eliquis or Ticlid). Your Gastroenterologist will need to determine if these medication dosages require adjustment prior to the procedure. Failure to properly adjust these medications may result in cancellation of your procedure. You may continue to take Aspirin as usual.

4. If you are having chest pain or you are undergoing cardiac testing please notify us before you begin to prep for your procedure.

5. Do not take iron, diet pills (Phentermine, Adipex or Qsymia) or herbal medications for 7 days prior to having your procedure. You may take vitamins.

6. Notify us in advance if you have ever had excessive bleeding after an operation or if you have had problems with anesthesia.

7. Do not drink alcohol for 24 hours before or after your procedure.

8. Notify us in advance if there is a possibility you are pregnant.

9. If you have dentures you may be required to remove them for the procedure.

10. Leave your valuables at home. If you have body piercings you will be asked to remove them prior to the procedure for your safety.

11. If you are a diabetic, do not take your diabetic medication the day of your procedure. Bring your medication with you so you can take it after your procedure.

12. If you have asthma please bring your inhaler with you.

13. Take your usual prescribed medications with no more than 2 tablespoons (one ounce) of water up to 3 hours prior to your appointment time.

14. Do not use items such as gum, hard candy, breath mints, smokeless tobacco, or illicit drugs such as Marijuana on the day of your procedure.
The endoscopic examination you are having will be performed at the G. I. Diagnostic and Therapeutic Center, L.L.C. Our Endoscopy Center is the equivalent of any hospital based outpatient facility and, for this reason, a facility fee for each procedure performed will be charged for the use of G.I. Diagnostic and Therapeutic Center, L.L.C., just as a hospital would charge for the use of its facilities. Some insurance carriers however, regard these tests as outpatient surgery. If your insurance carrier falls in this group, you may be required to pay a deductible for this service. Diagnostic colonoscopies are ordered for patients who have a history of prior colon polyps, colon cancer or other colon diseases. They may also be ordered for patients having signs and symptoms such as abdominal pain, weight loss, or bleeding. These diagnostic colonoscopies do not qualify as a screening colonoscopy and are generally subject to a patient’s deductible and co-insurance. Please familiarize yourself with your healthcare coverage.

In addition to the facility charge, you will also receive a charge from Gastro One for professional services provided by your physician for the endoscopic examination(s). The endoscopy center is owned by the physicians of Gastro One.

All charges will be submitted separately to your insurance carrier for consideration for payment according to the terms of your insurance plan. You may receive the following two statements:

- **G.I. Diagnostic and Therapeutic Center** – for use of its facilities
- **Gastro One** – for professional services provided by your physician, pathology if tissue is removed and submitted for examination, and Certified Registered Nurse Anesthetist (CRNA) services provided.

GI Diagnostic and Therapeutic Center, L.L.C. and the physicians of Gastro One provide charitable care to the community by referral from select charitable healthcare organizations.

Under the Federal Patient Self-Determination Act, we, as healthcare providers, are obligated to inform you that, as a competent adult or as the parent/legal guardian of a minor, you have the right to make advance decisions regarding your healthcare. If a life-threatening emergency occurs at G.I. Diagnostic and Therapeutic Center, L.L.C. it is the policy of Gastro One and G.I. Diagnostic and Therapeutic Center, L.L.C. to perform Cardiopulmonary Resuscitation (CPR) as necessary to stabilize our patients for transfer to an acute health care facility.
PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

1. Patients are treated with respect, consideration and dignity.
2. Patients are provided appropriate privacy.
3. Patients have the right to be free from both mental and physical abuse.
4. Patients have the right to have an appropriate assessment and management of pain.
5. Patients have the right of self-determination, which encompasses the right to make choices regarding life-sustaining treatment or care. It is the policy of G.I. Diagnostic and Therapeutic Center L.L.C., regardless of the contents of any advanced directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, that our personnel will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun, will be ordered in accordance with your wishes, advance directive, or health care power of attorney. Patients have the right to schedule procedures at an alternative facility.
6. Patient disclosures and records are treated confidentially, and, except when required by law, patients are given the opportunity to approve or refuse their release.
7. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
8. Patients are given the opportunity to participate in decisions involving their healthcare, except when such participation is contraindicated for medical reasons.
9. Information is available to patients and staff concerning:
   a. patient rights, including those specifically mentioned above;
   b. patient conduct and responsibilities;
   c. services available at the organization
   d. provisions for after-hours and emergency care
   e. fees for service
   f. payment policies
   g. patient’s right to refuse to participate in research
   h. advance directives
   i. credentialing of healthcare professionals
10. Patients are informed of their right to change physicians.
11. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.
12. Patients are provided with appropriate information regarding the absence of malpractice insurance coverage, if applicable.
13. Patients are informed about procedures for expressing suggestions to the organization and policies regarding grievance procedures and external appeals, as required by state and federal law regulations.
14. Patients shall have the right to exercise all patient rights without regard to sex, cultural, economic, educational or religious background or the source of payment for his/her care.
15. Patients shall have the right to the knowledge of the physician who has primary responsibility for coordinating his/her care and the names of the professional relationships of other physicians and non-physicians who will see him/her.
16. Patients shall receive information from his/her physician about his/her illness, course of treatment, and prospects for recovery in terms he/she can understand.

17. The patient shall receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

18. The patient has the right to be interviewed and examined in surroundings designed to assure reasonable privacy. This includes the right to have a person of one’s own gender present during certain parts of a physical examination, treatment, or procedure performed by a health care professional of the opposite sex; and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the patient was asked to disrobe.

19. When a patient does not speak or understand the predominant language of the community, he/she should have access to an interpreter.

20. Patients shall actively participate in decisions regarding their medical care, to the extent permitted by law this includes the right to refuse treatment.

21. Patients shall have full consideration of privacy concerning their medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.

22. Patients’ records and treatment communications shall be treated confidentially. The patient’s written authorization shall be obtained before his/her medical records are disclosed to anyone other than for treatment, payment, or healthcare operations.

23. Patients are entitled to reasonable responses to a reasonable request he/she may make for service.

24. Patients have the right to leave the facility even against the advice of his/her physician.

25. Patients have the right to reasonable continuity of care and to know in advance the time, location of the appointment, and the name of the physician providing the care.

26. In the event the organization is unable to render medical care, a complete explanation regarding the need to transfer to another facility or physician will be discussed with the patient and/or their personal representative.

27. Patients shall be advised that if his/her physician proposes to engage in or perform human experimentation affecting his/her care or treatment, the patient has the right to refuse to participate in such research projects.

28. Patients have the right to be informed by their physician or a delegate of his/her physician their discharge instructions upon discharge.

29. Patients have the right to receive an explanation of his/her bill, regardless of the source of payment.

30. Patients have the right to know the rules and policies which apply to their conduct while a patient of this medical practice.

31. Patient rights apply to the patient as well as to the person who has the legal responsibility to make decisions regarding medical care on behalf of the patient (personal representative).

Complaints regarding the violation of patient rights may be reported to the State of TN-
Department of Health – (615) 741-3111 or by accessing the following website
http://www.cms.hhs.gov/center/ombudsman.asp
Patient Responsibilities

The care a patient receives depends partially on the patient himself/herself. Therefore, in addition to patient rights, a patient has certain responsibilities. These responsibilities are presented to the patient in the spirit of mutual trust and respect.

1. Patients must provide accurate and complete information concerning their present complaints, past medical history, any medications including over-the-counter products and dietary supplements, any allergies or sensitivities and any other issues related to their health.
2. The patient is responsible for making it known whether he/she clearly comprehends the course of medical treatment and what is expected of him/her.
3. The patient is responsible for following the agreed upon treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician’s orders.
4. The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
5. The patient is responsible for his/her actions should he/she refuse treatment or does not follow his/her physician’s orders.
6. The patient is responsible for assuring that the financial obligations not covered by insurance for his/her care are fulfilled as promptly as possible.
7. The patient is responsible for being considerate and respectful of the rights of other patients and facility personnel.
8. The patient is responsible for being respectful of his/her personal property and the property of other persons in the facility.
9. The patient is responsible for informing his/her provider of any Living Will, Power of Attorney or other Advanced Directives.
10. The patient is responsible for providing a responsible adult to provide transportation home and remain with them as directed and/or indicated on the discharge instructions.

How to file a grievance: As a patient or a patient’s representative you may notify us in writing, telephone, or email of any wrong or hardship suffered that is the grounds of a complaint.

Contact Information: feedback@gastro1.com

Tennessee 1310 Wolf Park Drive, Germantown, TN 38138  901-624-5151
Tennessee 8000 Wolf River Blvd, Suite 105, Germantown, TN 38138  901-747-3630
Mississippi 7668 Airways Blvd, Building B, Southaven, MS 38671  662-349-695
BRIEF DESCRIPTION OF PROCEDURES:
Gastrointestinal Endoscopy is the examination of the digestive tract with lighted instruments. At the time of the examination the inside lining of the G.I. tract will be inspected thoroughly and may be photographed. A small portion of tissue may be removed for microscopic study (biopsy), or the tissue may be brushed or washed to collect cells for a special study. Polyps may be removed. A narrowed portion of the digestive tract can be stretched or dilated to a more normal size (esophageal dilation).

EGD (Esophagogastroduodenoscopy) is the examination of the esophagus, stomach and duodenum.

ESOPHAGEAL DILATION is the stretching of a narrowed portion of the esophagus with a dilator.

FLEXIBLE SIGMOIDOSCOPY is the examination of the anus, rectum, and left colon.

ENTEROSCOPY is the examination of the small intestine.

COLONOSCOPY is the examination of the entire colon.

POLYPECTOMY is the removal of small growths, called polyps, with the use of either a wire loop and electric current or a cold forceps.

BANDING is the application of tiny bands to an area to reduce the risk of bleeding.

INJECTION THERAPY is the injection of a medication or solution to treat or mark an area.

BRAVO is the temporary placement of a capsule in the lower esophagus to record pH acid levels. The capsule will pass out of the G.I. tract naturally within 48 hours.

ANESTHESIA is medication administered to achieve a level of moderate to deep sedation as deemed necessary by the nurse anesthetist and physician. BLOOD PRODUCTS are not administered in this facility.

ALTERNATIVES: Possible alternatives vary from each patient, as some alternatives may be inappropriate for a number of reasons. However, these potential alternatives include x-rays, surgery, no examination or other possible alternatives that have been explained to me.

POSSIBLE RISK AND COMPLICATIONS: These vary in frequency among different procedures but may include: (1) Infection; (2) Injury to the lining of the intestinal tract may result in a hole (perforation) of the wall; (3) Bleeding; (4) Irregular heartbeat or pneumonia; (5) Reaction to medication used for anesthesia, including cardiopulmonary arrest (stopping of heartbeat or breathing); (6) Dental damage; and/or (7) Death.

I know the doctor cannot tell me about every possible risk, alternative, complication or side effect, but we did discuss the major ones. I am also aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of the procedure. I consent to the participation of medical trainees during my procedure or monitoring by preceptors or credentialing agencies who are under the direct supervision of my physician.

I understand that because of the sedation I may receive for my procedure, I am to follow these instructions until the next day:
1. Do NOT drive a car or operate machinery.
2. Do NOT sign any legal documents
3. Do NOT make any significant decisions.
4. Do NOT consume any alcoholic beverages.

CONSENT
I certify that I understand the information regarding Gastrointestinal Endoscopy and that I have been fully informed of the risks, benefits, complications, or potential alternatives associated with the procedure(s) and anesthesia. I consent to the use of such anesthesia and drugs as may be necessary by the nurse anesthetist and physician. I consent to the taking and publication of any photographs obtained in the course of this procedure for the purpose of treatment and medical education.

I hereby authorize and permit ______________________________ M.D.
and whomever he/she may designate as his/her assistant(s) to perform upon me the procedure(s) of:

If any unforeseen condition(s) arises during this procedure, I request that the physician perform any additional procedures, operations, or administer medications/treatments that may be deemed medically necessary and/or appropriate. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the result of the procedure.

_________________________ ___________________________
Patient Signature Date/Time
_________________________ ___________________________
Witness Signature Date/Time

Revised 7/2014
DATE ______________________  REFERRED BY __________________________ CHART # ____________________________

PATIENT INFORMATION

NAME: (first) __________________________ (middle initial) ______ (last) __________________________

BIRTH DATE: _______/______/_______  GENDER: □ FEMALE  □ MALE  SOCIAL SECURITY #: __________________________

ADDRESS: __________________________________________________________

CITY: ___________________________  STATE: ___________  ZIP CODE: ______________

HOME PHONE: ___________  WORK PHONE: ___________  MOBILE PHONE: ___________  EMAIL: ________________________

CONTACT PREFERENCE: □ MOBILE PHONE  □ HOME PHONE  □ WORK PHONE  □ PATIENT PORTAL  □ OTHER_______

I WOULD LIKE TO RECEIVE PREVENTIVE CARE AND FOLLOW UP CARE REMINDERS: □ YES  □ NO

I CONSENT TO HAVING MY MEDICAL & DEMOGRAPHIC INFORMATION SHARED W ITH OTHER HEALTH CARE FACILITIES: □ YES  □ NO

PHARMACY NAME: __________________________  ADDRESS: __________________________  PHONE: ______________________

RACE: □ WHITE/CAUCASIAN  □ BLACK/AFRICAN AMERICAN  □ ASIAN  □ AMERICAN INDIAN OR ALASKA NATIVE
□ NATIVE HAWAIIAN/PACIFIC ISLANDER  □ MIXED  □ OTHER  □ UNKNOWN  □ I DECLINE TO PROVIDE INFORMATION

ETHNICITY: □ HISPANIC OR LATINO  □ NOT HISPANIC OR LATINO  □ I DECLINE TO PROVIDE INFORMATION

PREFERRED LANGUAGE: □ ENGLISH  □ SPANISH  □ OTHER______  MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

EMPLOYER NAME: __________________________  ADDRESS:____________________________

EMERGENCY CONTACT: __________________________  RELATIONSHIP: ______________  PHONE: ______________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: __________________________________________________________

INSURANCE CO. ADDRESS: _________________________________________________________________

NAME OF POLICYHOLDER: ___________________________  DATE OF BIRTH: _______________________

ID OR SOC SECURITY #: __________________________ GROUP #: __________________  RELATIONSHIP TO PATIENT: ______________

POLICYHOLDER’S ADDRESS (IF other than patient): _______________________________________________________________________

POLICYHOLDER’S EMPLOYER (IF other than patient): __________________________  PHONE #: __________________

POLICYHOLDER EMPLOYER’S ADDRESS (IF other than patient): _______________________________________________________________________

SECONDARY INSURANCE COMPANY NAME: __________________________________________________________

INSURANCE CO. ADDRESS: _________________________________________________________________

NAME OF POLICYHOLDER: ___________________________  DATE OF BIRTH: _______________________

ID OR SOC SECURITY #: __________________________ GROUP #: __________________  RELATIONSHIP TO PATIENT: ______________

POLICYHOLDER’S ADDRESS (IF other than patient): _______________________________________________________________________

POLICYHOLDER’S EMPLOYER (IF other than patient): __________________________  PHONE #: __________________

POLICYHOLDER EMPLOYER’S ADDRESS (IF other than patient): _______________________________________________________________________
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release or disclose of all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: ___________________________________________ Date of Birth: ________________________

☐ I hereby authorize the release of my medical records TO GASTRO ONE from ALL MEDICAL SOURCES so that my physician has the information he/she needs to provide medical care.

☐ I only authorize the release of my medical records from ________________________________________________ TO GASTRO ONE

☐ I hereby authorize the release of my medical records at GASTRO ONE to the following:

____________________________________________________________________________________________

Purpose of the disclosure is for medical care unless otherwise specified here:

_______________________________________________________________________________________________

The authorization will expire on: __________________________________________ Date or Event may not exceed one year

This authorization applies to: Date or Event may not exceed one year

☐ All medical records
☐ Health care information only relating to the following treatment(s), condition(s) or dates of treatment:

_____________________________________________________________________________________________

☐ Limited records to be released (examples lab work reports, imaging reports), specify:

_____________________________________________________________________________________________

If you DO NOT WANT certain portions of your medical records released, please initial the box indicating the information you do not want released or specify:

☐ Substance abuse ☐ Psychological or psychiatric treatment ☐ HIV/AIDS/STD

_____________________________________________________________________________________________

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient or Authorized Representative Date Signed

Relationship to Patient
Patient Interview Form

First Name_________________________________Last Name_____________________________________

Allergies □ None □ Penicillin □ Sulfa □ Latex □ Iodine □ Eggs □ Others _________________

Current Medications Please list meds below including non-prescription medications (use back if needed)

□ None

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>How Taken</th>
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</tbody>
</table>

I consent to obtaining a history of my medications purchased at pharmacies. □ yes □ no
### Immunizations
- □ None
- □ Hep A
- □ Hep B
- □ Flu
- □ Pneumonia
- □ TB

Date: 

### Diagnostic Studies
- □ None
- □ Colonoscopy
- □ Endoscopy

Date: 

### Past or Present Medical Conditions
#### GI Related Illnesses:
- □ None
- □ Cirrhosis
- □ Colon cancer
- □ Colon polyps
- □ Crohn’s Disease
- □ Diverticulitis
- □ Esophagitis/GERD
- □ Gallstones
- □ Hepatitis
- □ Irritable Bowel
- □ Pancreatitis
- □ Stomach /Duodenal Ulcer

#### Other Illnesses:
- □ None
- □ Bleeding Disorder
- □ Blood Transfusions
- □ Glaucoma
- □ High Cholesterol
- □ Osteoporosis
- □ TB or positive TB skin test
- □ Thyroid Disease
- □ Cancer

Other illnesses: ________________________________________________________________________

### Previous Surgeries:
- □ None
- □ Appendectomy
- □ CABG
- □ Heart Valve
- □ Colon Resection
- □ Gallbladder removed
- □ Hemorrhoidectomy
- □ Hiatal Hernia
- □ Hysterectomy
- □ Obesity Surgery
- □ Ovary Surgery
- □ Stomach Surgery
- □ Tubal Ligation
- □ Other surgeries

Other surgeries: ________________________________________________________________________

### Social History

Occupation: ________________________________________________________________________

Marital Status
- □ Single
- □ Married
- □ Divorced
- □ Widowed

Alcohol Use
- □ None
- □ < 5 drinks per wk
- □ 5 to 15 drinks per wk
- □ > 15 drinks per wk

Tobacco Use
- □ None
- □ < 1 pack per day
- □ 1-2 packs per day
- □ > 2 packs per day
- □ Former smoker

Recreational Drug Use
- □ None
- □ Marijuana
- □ Cocaine
- □ Other

Exercise
- □ None
- □ < 3 days per week
- □ 3-5 days per week
- □ > 5 days per week
**Family Medical History**

Do you have any family history of the following:

- [ ] No knowledge of family history
- [ ] Family history of colon cancer
  - Who ___________________ Age ____________
- [ ] Family history of colon polyps
  - Who ___________________ Age ____________
- [ ] Celiac disease
  - Who ___________________ Age ____________
- [ ] Crohn’s disease
  - Who ___________________ Age ____________
- [ ] Ulcerative colitis
  - Who ___________________ Age ____________
- [ ] Esophageal cancer
  - Who ___________________ Age ____________
- [ ] Ovarian cancer
  - Who ___________________ Age ____________
- [ ] Pancreatic cancer
  - Who ___________________ Age ____________
- [ ] Stomach cancer
  - Who ___________________ Age ____________
- [ ] Uterine cancer
  - Who ___________________ Age ____________

**Review Of Systems** Check the boxes for symptoms you have had during the last 6 months.

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Hematologic/Lymphatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Ankle Swelling</td>
<td>□ Easy Bruising</td>
</tr>
<tr>
<td>□ Chest pain</td>
<td>□ Prolonged Bleeding</td>
</tr>
<tr>
<td>□ Irregular heart beat</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Integumentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Fatigue</td>
<td>□ Itching</td>
</tr>
<tr>
<td>□ Fever</td>
<td>□ Jaundice</td>
</tr>
<tr>
<td>□ Loss of appetite</td>
<td>□ Rash</td>
</tr>
<tr>
<td>□ Weight gain</td>
<td></td>
</tr>
<tr>
<td>□ Weight loss</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Ears/Nose/Mouth/Throat</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hoarseness</td>
<td>□ Back Pain</td>
</tr>
<tr>
<td>□ Sore Throat</td>
<td>□ Joint Pain</td>
</tr>
<tr>
<td></td>
<td>□ Muscle Pain</td>
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<table>
<thead>
<tr>
<th>Endocrine</th>
<th>Neurological</th>
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</thead>
<tbody>
<tr>
<td>□ Excessive Thirst</td>
<td>□ Dizziness</td>
</tr>
<tr>
<td>□ Cold Intolerance</td>
<td>□ Fainting</td>
</tr>
<tr>
<td>□ Heat Intolerance</td>
<td>□ Frequent Headaches</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Gastrointestinal</th>
<th>Psychiatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Abdominal Pain</td>
<td>□ Anxiety / Panic</td>
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<tr>
<td>□ Belching</td>
<td>□ Depression</td>
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<tr>
<td>□ Black Stools</td>
<td>□ Difficulty Sleeping</td>
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<tr>
<td>□ Bloating</td>
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<tr>
<td>□ Change in Bowel Habit</td>
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<tr>
<td>□ Constipation</td>
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<td>□ Dairy Intolerance</td>
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<tr>
<td>□ Diarrhea</td>
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<td>□ Difficulty Swallowing</td>
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<tr>
<td>□ Painful Swallowing</td>
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<tr>
<td>□ Flatulence/rectal gas</td>
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<td>□ Heartburn/Reflux</td>
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<td>□ Nausea</td>
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<td>□ Painful stools</td>
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<td>□ Rectal Bleeding</td>
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<td>□ Rectal Protrusions</td>
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<td>□ Rectal Urgency</td>
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<td>□ Soiling/Incontinence</td>
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<td>□ Flatulence</td>
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<td>□ Heartburn</td>
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<tr>
<td>□ Vomiting</td>
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Revised 8/2015 clinic
GASTRO ONE
G.I. DIAGNOSTIC AND THERAPEUTIC CENTER, L.L.C.

APPOINTMENT REQUEST (Please check one)

You have asked to see a Gastro One physician or your physician has recommended one of the physicians at Gastro One.

[ ] SELF REQUESTED
[ ] PHYSICIAN REQUESTED

Full Name of the physician requesting an evaluation from a Gastro One physician.

____________________________________________________________________

EMERGENCY CARE

In the event of a life threatening emergency, it is the policy of Gastro One to perform Cardiopulmonary Resuscitation (CPR) as necessary to stabilize our patients for transfer to an acute care health facility.

( ) YES   ( ) NO   DO YOU HAVE A LIVING WILL?

( ) YES   ( ) NO   ARE YOU AN ORGAN DONOR?

COMMUNICATIONS REGARDING YOUR HEALTH CARE INFORMATION

Please indicate with whom we may discuss your healthcare. Check all that apply.

( ) I hereby authorize Gastro One to leave messages regarding pending appointments or tests at my residence.

( ) Gastro One may communicate information regarding my healthcare with the individuals listed below:

Name_________________________ Relationship____________________

Name_________________________ Relationship____________________

Name_________________________ Relationship____________________

( ) Gastro One may not communicate my healthcare information with anyone other than me.

CONSENT FOR CARE

The physicians & staff of Gastro One &/or the G.I. Diagnostic and Therapeutic Center, L.L.C. will be hereafter referred to as “Gastro One”. I hereby give my consent for treatment. My signature on this form indicates I have received a copy of the “Notice of Privacy Practices” from Gastro One and I understand how my health care information will be used and/or disclosed.
MEDICARE EXTENDED PAYMENT REQUEST  
(one time authorization)
I request payment of authorized Medicare benefits to be made either to me or on my behalf to: the physicians of Gastro One and/or G. I. Diagnostic & Therapeutic Center, L.L.C. for any services provided to me. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicaid Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL POLICY

Please familiarize yourself with your healthcare coverage. We are committed to providing our patients with the best possible care. If you have medical insurance, we will do all that we can to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. If you are enrolled in a managed care plan, you are responsible for informing Gastro One of any special requirements of your insurance plan. If lab work or other diagnostic tests are ordered and sent to an outside lab or other facility, you will be billed directly by the outside lab or facility and payment is your responsibility. We will file your insurance claim for you; however, we ask that you pay any co-payment or deductible at the time our services are rendered and the balance in full within 90 days regardless of insurance filing. We accept Cash, Check, American Express, Discover, MasterCard, or Visa. We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If your account is turned over to a professional collection agency you may be dismissed from care by physicians employed by Gastro One &/or G.I. Diagnostic & Therapeutic Center, L.L.C.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you. I have read and understand this explanation of the financial policy of Gastro One and hereby authorize the release of any medical information deemed necessary to process any insurance claim for services rendered. This form is authorization for all medical benefits from any insurance company on said claims to be paid directly to Gastro One &/or G.I. Diagnostic & Therapeutic Center, L.L.C.

“No Show” Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations. However, when you do not call to cancel an appointment, another patient may be prevented from receiving needed care.

As part of our continued effort to provide you with the best care and accommodate all appointment requests, Gastro One has implemented a “No Show” Fee Policy. If you fail to show up for your scheduled appointment, Gastro One and G.I. Diagnostic & Therapeutic Center reserve the right to charge a fee of $25.00 for all missed office visits and $75.00 for all missed procedure appointments.

“No Show” fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of our patients.

My signature indicates I have read and understand the information on the front and back of this form.

Signature________________________________________________________Date_____________________

_________________________________________
The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, diagnoses, treatment, test results, and applying for future care or treatment. It also includes billing documents for those services. Examples of uses of your health information for treatment purposes are: A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of use of your health information for payment purposes: We submit requests for payment to your health insurance company. A health insurance company or business associate helping us obtain payment requests information from us regarding your medical care. We will provide information to them about you and the care given. Examples of Use of Your Information for health care operations: We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

**Patient Health Information Rights** - The health and billing records we maintain are the physical property of the practice. You have the following rights with respect to your protected health information: to request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will attempt to comply with any reasonable; to obtain a paper copy of the Notice of Privacy Practices for Protected Health Information (“Notice”) by making a request at our office; to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request. An amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information; to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care; to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request. If you want to exercise any of the above rights, please contact the supervisor of your respective practice site during normal hours. All requests should be in writing. You will be provided with assistance regarding exercising your rights.

**Our responsibilities and requirements:** Maintain the privacy of your health information, as required by law; provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; abide by the terms of this Notice; notify you if we cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you; and accommodate your request for an accounting of disclosures. We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice” or by visiting any of our practice sites and picking up a copy.

**To Request Information or File a Complaint** - If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the supervisor for your respective treatment site or the Privacy Officer @ 901-747-3630. Additionally, if you believe your privacy rights have been violated, you may file a written complaint with our office by delivering the written complaint to the Privacy Officer @ 8000 Wolf Rvier Blvd. #200, Germantown, Tennessee 38138. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services. [U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, (202) 619-0257 or Toll Free: 877-696-6775 www.hhs.gov/ocr/hipaa/ We cannot, and will not, require you
to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule

Patient Contact: We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may contact you as part of a fund raising effort. If we are unable to reach you by telephone, we will exercise our professional judgment with leaving results of tests and/or procedures on your answering machine. Notification – Opportunity to Agree or Object: Unless you object we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. Communication with Family: If you do not object or in an emergency, using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person’s involvement in your care or in payment for such care. We may use and disclose your protected health information to assist in disaster relief efforts.

Opportunity to Agree or Object Not Required - Public Health Activities Controlling Disease - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. Abuse & Neglect - We will disclose protected health information to public authorities as required by law to report abuse or neglect. We may disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and if in the exercise of professional judgment, the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victims. Food and Drug Administration (FDA) - We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements. Work Related Injury or Illness - With medical surveillance or the evaluation of whether an individual has a work related injury or illness, the organization may disclose protected health information pertaining to a work related injury or illness to the employer if the employer needs the findings in order to comply with OSHA regulations. Oversight Agencies - Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare. Judicial / Administrative Proceedings - We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process. Law Enforcement - We may disclose your protected health information for law enforcement purposes as required by law; such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury. Coroner, Medical Examiners and Funeral Directors - We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties. Organ Procurement Organizations - Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant. Research - We may disclose information to researchers when an institutional review board, which has reviewed the research proposal and established protocols to ensure the privacy of your protected health information, has approved their research. Threat to Health and Safety - To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public. For Specialized Governmental Functions - We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel. Correctional Institutions - If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals. Workers Compensation - If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation. Other Uses and Disclosures - Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Website - We maintain a website that provides information about our entity; this Notice is on the website.

Effective Date: April 14, 2003

Last Revision 04/06/15

Form # 2.37