Miami Gastro LLC

PATIENT INFORMED CONSENT FOR TREATMENT AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

GENERAL TREATMENT CONSENT: The undersigned has voluntarily presented for medical care and consents to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary or appropriate for the purpose of diagnosis. Procedures or exams may include, but are not limited to upper endoscopy, colonoscopy, breath tests, capsule endoscopy, fibroscan, hemorrhoid banding, ultrasound, and rectal examination. The undersigned understands that the nature of, intended purpose, potential risks/complications, and alternatives for each procedure or treatment will be explained to him/her beforehand. The undersigned understands and acknowledges that no warranty or guaranty has been or will be made as to the result or cure of treatment.

VIDA SCIENCES LLC, a clinical trials research company, may seek your eligibility for new diagnostic or therapeutic interventions and offer you a clinical trial study if you qualify.

NOTICE OF PRIVACY PRACTICES ACKOWLEDGEMENT: The undersigned understands he/she has a right to review the Provider's Notice of Privacy Practices prior to signing this document and acknowledges that the Provider's Notice of Privacy Practices has been made available to him/her. The Notice of Privacy Practices for the Provider is also provided in the waiting room.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Patient Request for Confidential Communications of Protected Health Information

The Health Insurance Portability Act of 1996 ("HIPAA") provides you the right to request that **Miami Gastro LLC** communicate with you about your health information at an alternative address or phone number, or by an alternative means (for example, by email) that is more confidential for you. **Miami Gastro LLC** must accommodate your request if it is reasonable. **Miami Gastro LLC** may require you to specify an alternative address or other method of contact before providing the requested accommodation. If your request is accepted, the Medical Center will make every attempt to communicate with you in the manner you have requested. Your election will remain in effect until you have instructed us in writing to change the manner of communication.

To request confidential communications, please complete the form below and send to:

Miami Gastro LLC 925 NE 30th Terrace, Suite 204. Homestead, FL 33033

Patient Name: _____ Telephone #: _____
(Print)

Address: _____City:_____State:_____Zip:_____

Describe the alternative means of communication you are requesting:
TEXTS AND/OR VOICEMAILS

_____

I am requesting **Miami Gastro LLC** communicate with me by an alternative means or at an alternative address or phone number that is more confidential for me. I understand that the Medical Center will not accommodate unreasonable requests.

_____ Date Signed _____ /_____ /_____
Signature of Patient or Legal Representative *May be requested to show proof of representative status

REMINDER: If the alternative address selected by patient is an e-mail, then E-Mail Consent Form MUST be completed.

E-Mail Consent Form

Purpose: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information (PHI).

Miami Gastro LLC offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before granting consent to use e-mail for these purposes. **Miami Gastro LLC** will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, **Miami Gastro LLC** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of e-mail between **Miami Gastro LLC** and me and consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that **Miami Gastro LLC** may communicate with me regarding my protected health information by e-mail.

My Consented E-Mail Address is : _____

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

PATIENT'S INFORMATION

Date : _____

Patient's Name: _____

Address:_____

City: _____ State: _____ Zip Code _____

Phone Number : _____ E-mail: _____

Cell Number: _____

Age:_____ Marital Status: _____ Date of Birth: _____
Social Security #: _____

Employer: _____
Address: _____
Position: _____

Name of Nearest Relative: _____ Phone_____

Referred by: _____ Phone: _____

INSURANCE

Medicare#:_____ Medicaid:_____
Suplementary Insurance #:_____
Policy # / No de Poliza: _____

HMO _____ PPO _____
Do you have another Insurance? YES _____ NO _____

Allergies: _____

What medications are you taking? / Que medicamentos esta tomando? :

Name	Dose	Frequency

I hereby authorized payment directly to **Miami Gastro LLC** of benefits due to me from my insurance company otherwise payable to me. I also authorized the release of any medical information required by my insurance carrier. A copy of this authorization may be used in lieu of the original. I authorized any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing. Administration or its intermediaries or carries of any information for this or a related Medicare claim, I request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information (PHI) may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc. to ensure that the healthcare provider has the necessary information to diagnose or treat you. Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant PHI be disclosed to the health plan to obtain approval for the procedure. Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your PHI for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your PHI when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your PHI for marketing purposes. We may not sell your PHI without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your PHI that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. YOUR RIGHTS You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your PHI whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, PHI restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality

CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to the use or disclosure of my protected health information by **Miami Gastro, LLC** (the "**Provider**") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Provider. I understand that diagnosis or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Provider is not required to agree to the restrictions that may

request. However, if the provider agrees to a restriction that I request, the restriction is binding on the provider and all physicians associated with the Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent the Provider has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider a healthcare plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies, or there is a reasonable basis to believe the information may identity me.

I understand I have a right to review the Provider's Notice of Privacy Practices prior to signing this document. The Provider's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Provider. The Notice of Privacy Practices for the Provider is also provided in the waiting room. This Notice of Privacy Practices also describes my rights and the Provider's duties with respect to my protected health information.

The Provider and all physicians associated with the Provider reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative Description of Personal Representative's Authority

DOCUMENTATION OF GOOD FAITH EFFORTS

Patient Name _____

Date _____

The patient presented for treatment on this date and was provided with a copy of the Provider's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of the receipt of the notice. However, an acknowledgement was not obtained because:

Patient refused to sign.
Patient was unable to sign or initial because:

_____

There was a medical emergency (the Provider will attempt to obtain acknowledgement at the next available opportunity).
Other reason, described below:

_____

Signature of employee completing form:

x _____ Name:_____

Miami Gastro LLC

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

Miami Gastro LLC
Danny J. Avalos M.D
925 NE 30th Terrace, Suite 204
Homestead, FL 33033
Office: 305-974-4822
Fax: 509-420-9737

Date: _____

Recipient:

_____

_____

_____

I hereby authorize and request you to release to the above doctor the complete history records in your possession concerning my illness and/or treatment during the:

Period from: _____ To: _____

Name: _____ Date: _____

Social security: _____-____-_____ Date of birth: _____

Home address: _____

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority