SOUTHERN GASTROENTEROLOGY ASSOCIATES

SOUTHERN GASTROENTEROLOGY ENDOSCOPY CENTER

Patient Information and Consent for Treatment

Name _____ Birth Date _____

Preferred Name _____ SSN _____

Mailing Address _____

Physical Address (if different) _____

Home Phone _____ Work Phone _____

Cell Phone_____ Email _____

Race ( ) African American ( ) American Indian or Alaska Native ( ) Asian ( ) White ( ) Other:_____

Marital Status ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other: _____

Occupation _____ Employer _____

Emergency Contact _____

Phone _____ Relationship _____

Primary Care Physician _____ Referred by _____

Preferred Pharmacy (with address) _____

Preferred Method of Contact: (Check all that Apply)

( ) Mail ( ) Phone Call ( ) Text ( ) Email ( ) Athenahealth Patient Portal

Consent for practice to leave messages on patient provided phone numbers ( ) Yes ( ) No

Consent to obtaining a history of my medications purchased at pharmacies ( ) Yes ( ) No

Consent to publish data to patient portal ( ) Yes ( ) No

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____ Birth Date _____

Address _____

Home Phone _____ Cell Phone _____

Work Phone_____ Employer _____

Insurance Information

Primary Insurance

Policy Holder Name _____ Relationship _____

Insurance Company _____ Member ID # _____

Secondary Insurance
Policy Holder Name _____ Relationship _____

Insurance Company _____ Member ID # _____

Assignment of Benefits and Authorization for Release of Information

I authorize the release of any information concerning health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits directly to this organization. I am financially responsible for non-covered expenses. As a service to you, we will file your insurance claim with the necessary information in a timely fashion. Most insurance policies will not cover the entire expense for your care. If your insurance requires a co-pay, that will be due at check-in for each visit. Any amount you may owe as a portion of your deductible or coinsurance will be billed to you. You may receive notice via mailed statement, text message, email, or patient portal notification, depending on how you choose to be notified. For your convenience, we accept cash, checks, and most major credit cards. If you have any questions about your bill, you may contact our office at 434-572-8196, Opt. 6. Any unpaid balances will be transferred to collections after 90 days. Payment plans are available, if necessary.

Permission to Discuss Personal Health Information (PHI)

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

Consent for Treatment

By appearing for this appointment, I consent to an assessment, diagnosis, and treatment for my presenting complaints. I agree to provide complete information related to my health and medications taken.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Southern Gastroenterology Associates, PC and/or Southern Gastroenterology Endoscopy Center, PC. I understand that I am financially responsible for any balance. I also authorize Southern Gastroenterology Associates, PC, Southern Gastroenterology Endoscopy Center, PC, and/or insurance company to release any information required to process my claims.

Patient or Guardian Signature: _____ Date: _____

Relationship to Patient: _____ ( ) NA

SOUTHERN GASTROENTEROLOGY ASSOCIATES

SOUTHERN GASTROENTEROLOGY ENDOSCOPY CENTER

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 READ CAREFULLY. This organization has a legal duty to safeguard your protected health information.

This Privacy Notice is being given to you as a requirement of federal law. The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This notification describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. As a patient, you have the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information. We have prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

Summary of Your Rights to Privacy

You have the following rights with respect to your PHI:

- The right to see and copy your PHI with completion of a written request.
- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you.
- The right to reasonable requests to receive confidential communications of PHI by alternative means with completion of a written request.
- The right to request an amendment of PHI about you except for information not created by us, information that we believe is correct and complete; or information that is no pare of the record used to make decisions about your healthcare.
- The right to receive a list of disclosures of your PHI within the last 6 years upon written request, but we charge a reasonable cost-based fee for the second or more request in any 12-month period.
- The right to receive a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.
- The right to file a written complaint about our privacy practices or any perceived breach of healthcare information.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

How We May Use of Disclose Your Information

We may use and disclose your medical records for each of the following purposes: treatment, payment, health care operation, and legally required disclosure.

A. Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor. For example, we may share your PHI with the pharmacy to fill a prescription or to the lab to order blood tests.

B. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and /or verifying coverage prior to surgery. For example, we must share your PHI with the insurance company to get prior approval for your procedure.

C. Healthcare operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer

service. An example of this would be new patient survey cards. For example, training programs for employees, performance review, quality improvement activities, accreditation / inspections by regulatory organizations.

In all situations, we will do our best to assure continued confidentiality to the extent possible. For example, subpoenas for records.

Other Use and Disclosure Without Authorization of Opportunity to Object

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. Other uses include the following:

A. As Required by Law – disclosure will be made as required by any federal, state, or local law or other judicial or administrative proceeding.
B. Public Health Activities – disclosure will be made to prevent, control, or report diseases or injuries required by law; to report vital events such as death; to conduct public health surveillance or investigations; to collect and report adverse events and product defects or to enable recall of drugs, products, or equipment; to notify a person who has been exposed to a communicable disease; or to report information to an employer as legally permitted or required.
C. Victims of Abuse, Neglect, or Domestic Violence – disclosure will be made to notify governmental authorities if we believe a patient is a victim of abuse, neglect, or domestic violence only when specifically required or authorized by law or when a patient agrees to the disclosure.
D. Health Oversight Activities – disclosure will be made to a healthcare oversight agency including audits for civil, criminal, administrative investigations, proceedings, or actions and for inspections related to licensure or disciplinary actions. We will not disclose your health information if you are the subject of an investigation, and your health information is not directly related to your receipt of health care or public benefits.
E. Judicial and Administrative Proceedings – disclosure will be made for judicial or administrative proceedings in response to a court order or subpoena to the extent authorized by law if we receive satisfactory assurances that you have been notified of the request or that efforts were made to secure a protective order.
F. Law Enforcement Purposes – disclosure will be made to law enforcement as required by law for reporting certain types of wounds or injuries; pursuant to a court order, warrant, subpoena, summons; for identifying or locating a suspect, fugitive, material witness, or missing person; and in an emergency to report a crime.
G. Coroner, Funeral Director, and Organ Donation – disclosure will be made to a coroner or medical examiner for identification, examination for cause of death; to a funeral director to allow the carrying out of their duties in reasonable anticipation of death; and to organ donation organization for donation purposes.
H. Research Purposes – disclosure will be made when disclosure has been approved by an institution review board.
I. Workers Compensation – disclosure will be made to comply with workers compensation laws.

The following use and disclosures of PHI will <u>only</u> be made pursuant to us receiving a written authorization from you:

- Use and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosure that constitutes a sale of PHI under HIPAA; and
- Other use and disclosure not described in this notice.

You Can Object to Certain Use and Disclosure

You may revoke or object to certain disclosures in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your prior authorization. If you would like to object to disclosure of your health information to a family member, relative, or close friend who is directly involved in your care or for payment purposes, please contact the person listed below. We will request that you sign a written authorization and indicate people who may have access to your health information. You may revoke or change this authorization in writing at any time. We will not disclose health information after we receive the revised authorization except for disclosures that were being processed before we received the revision.
It is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post/provide a copy in our waiting room, and you may request a written copy of the Notice of Privacy Practice at any time.

Contact Information to Request Information or to File a Complaint

The contact information for any request or to address issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer list below. We encourage you to express any concerns you may have regarding the privacy of information. You will not be retaliated against in any way for filing a complaint. All complaints will be investigated to help resolve any identified issues.

Name: Brianna Taylor
Phone Number: 434-572-8196
Address: 1129 N Main St, STE G, South Boston, VA 24592

You have recourse if you feel that our office has violated your privacy. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

SOUTHERN GASTROENTEROLOGY ASSOCIATES

SOUTHERN GASTROENTEROLOGY ENDOSCOPY CENTER

Your Rights and Responsibilities as Our Patient

This center is a physician owned facility. You may exercise the following rights without being subjected to discrimination or reprisal.

Patient Rights – You have a right to:

- Considerate, respectful, and safe care that is free from abuse or harassment.
- A discussion of your illness, what we can do about it, and the likely outcome of care.
- Know the names and roles of the people caring for you here.
- Respectful and effective pain management.
- Receive as much information to consent to or refuse a course of treatment or invasive procedure and to actively participate in decisions regarding your medical care.
- Involve your health care proxy or significant others in the decision-making process for medical decisions.
- Reasonable continuity of care and to know in advance the time and location of an appointment as well as the doctor you are seeing.
- Full consideration of personal privacy and confidentiality of your medical information. Your written permission will be obtained prior to releasing any medical information. When we do release your information to others, we ask them to keep it confidential.
- Review your medical record and ask questions unless restricted by law.
- Know of any relationships with other parties that may influence your care.
- Know about rules that affect your care and about charges and payment methods. You have a right to receive and examine an explanation of your bill regardless of the source of payment.
- Receive assistance with the transfer of care from one doctor to another doctor within our practice or to an external doctor not in our practice.
- You have a right to develop a living will or healthcare power of attorney although, since the procedures that we do are not high risk, we will do all that is necessary to stabilize you including CPR if an emergency occurs. EMS will be called, and you will be transferred to the hospital.
- Voice your concerns, complaints, or problems with the care you received by contacting our manager. If we are unable to satisfactorily address your complaint, you may contact the State Medical Board by phone at 1-800-253-9653, AAAHC by phone at 1-847-853-6060 or online at www.aaahc.org,

Patient Responsibilities - You agree to:

- Provide accurate and complete information concerning your symptoms, history, current health status, and medications including over-the-counter products and dietary supplements.
- Make known whether you clearly comprehend your medical care and what is expected of you in the plan of care.
- Participate in the development of the treatment plan and follow care instructions given to you.
- Follow the treatment plan and care instructions given to you.
- Keep appointments and notify us if you are unable to do so.
- Accept responsibility for your actions if you refuse planned treatment or do not follow your doctor's orders.
- Accept financial responsibility for care received and pay promptly.
- Follow facility policies and procedures.
- Inform my doctor about any living will, medical healthcare power of attorney, or other directive that may affect my medical care.
- Be respectful of all healthcare providers and staff as well as other patients.
- Inform the staff of any discomfort or pain and patient safety issues.
- Share your values, beliefs, and traditions to help the staff provide appropriate care.
- Provide a responsible adult to transport you home and remain with you if you receive sedation medications.
- Provide any Advance Directive information.

Revised 07/2024

SOUTHERN GASTROENTEROLOGY ASSOCIATES

SOUTHERN GASTROENTEROLOGY ENDOSCOPY CENTER

Patient Acknowledgement of Notice of Privacy Practices and Patient Rights & Responsibilities

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and, understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I acknowledge that I have been given the opportunity to read and receive a copy of the Patient Rights and Responsibilities prior to my procedure, which includes the following items:

- My rights and responsibilities as a patient
- Notification that this is a physician owned facility
- Contact information for advance directive information (living will or healthcare power of attorney)
- Our policy regarding not honoring a living will or Do Not Resuscitate in the center
- Our complaint / grievance process and contact information to make suggestions or to register a complaint.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

Relationship to Patient: _____ ( ) NA

Office Use Only

I attempted to obtain the patient's signature in acknowledgement but was unable to do so as documented below.

Date: _____ Reason: _____

Signature: _____

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SOUTHERN GASTROENTEROLOGY ASSOCIATES

SOUTHERN GASTROENTEROLOGY ENDOSCOPY CENTER

Financial Policy

We are committed to providing you with the best possible medical care; if you have special needs, we are here to assist you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is YOUR responsibility to verify insurance plan coverage and benefits:
    a. Bring your insurance card every visit, all co-pays, and any previous balances at the time of service.
    b. Be prepared to provide a form of identification, indicating address, one with a picture.
    c. If your insurance requires a co-pay, that will be due at check-in for each visit.
    d. Any amount you may owe as a portion of your deductible or coinsurance will be billed to you.
    e. You will be notified of outstanding balances via mailed statements, text message, email, and/or patient portal notification, depending on how you choose to be notified.
    f. Payment can be made by cash, check, debit, or credit card. Returned checks will be assess a fee of $35.00.
2. If you have insurance that we do not participate in, our office is happy to file the claim; however, a down payment of $100 is due at check in for each visit. You will be responsible for the remainder of the billed amount for any services rendered.
3. Referrals: it is your responsibility to bring any required referrals for treatment at, or prior to, the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.
4. If you do not have insurance, a down payment of $100 is expected at the time of check-in for each visit. You will be eligible for a Sliding Fee Scale of 30% off all billable services rendered at our practice. You will be responsible for the remainder of the billed amount for those services. SGA/SGEC offers payment plans with a minimum of a $25 payment each month, please inquire if necessary.
5. If the patient is a minor (age 18 and younger), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.
    a. In certain situations, parent or guardian signature is not required. *
6. If you have questions about your insurance or an outstanding balance, you may contact our office at 434-572-8196, option 6. Specific coverage issues, however, should be directed to your insurance company member services department (number is on the insurance card).
7. If you fail to make payment in full for the services that are rendered to you, within 90 days, the outstanding balance will be sent to a collection agency. You will be responsible for and agree to pay all reasonable collection costs including late charges, interest, court costs and/or attorney's fees.
8. If you fail to make attempts to pay a balance or set up a payment plan, you can be dismissed from the practice.
9. Anesthesia services at Southern Gastroenterology Endoscopy Center are billed separately. See below for contact information for Gill's Anesthesia billing services:

    Gill's Anesthesia (HMBS Billing)
    844-469-4936

10. I authorize Southern Gastroenterology Associates and/or Southern Gastroenterology Endoscopy Center and its agents, the use of any telephone number and emails provided to them or published, to message or contact me regarding my accounts.

SOUTHERN GASTROENTEROLOGY ASSOCIATES

SOUTHERN GASTROENTEROLOGY ENDOSCOPY CENTER

No-Show Policy

Any patient who fails to arrive for a scheduled appointment is considered a no-show and will be charged a $25 fee, unless there are unforeseen circumstances that are out of the patient's control. A patient who no-shows more than three times may be dismissed from the practice. If you are more than 15 minutes late for a scheduled appointment, you will have to reschedule.

Scheduled Procedures

We require 72 hour (3 day) prior notification if you need to cancel or reschedule a procedure. Failure to notify us 72 hours (3 days) prior to your scheduled procedure may result in a fee of $200.00. This fee will not be submitted to insurance. It is your responsibility and must be paid in full prior to scheduling your next appointment. Please call our office at 434-572-8196 during business hours (Mon-Fri 8:30AM-5:00PM) to cancel or reschedule a procedure.

Sentara Halifax Regional Hospital: After business hours, if your procedure is scheduled to be completed at Sentara Halifax Regional Hospital, you may cancel your appointment by calling Sentara Halifax Regional Hospital and speaking with the house supervisor on call or the on-call GI provider.

Southern Gastroenterology Endoscopy Center: If you are scheduled to complete your procedure at Southern Gastroenterology Endoscopy Center, please call our office during business hours at 434-572-8196 as there is not an after-hours service.

It is the patient's responsibility to keep up with appointments and instructions. If you have questions about appointment times, procedure instructions, etc. please call our office at 434-572-8196 to speak with a staff member. Our staff may need to call you to notify you of schedule changes or with questions, so please make sure that we have your current contact phone number on file.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Please sign that you have read and agree to the terms of the Financial Policy and No-Show Policy.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

Relationship to Patient: _____ ( ) NA

Office Use Only

I attempted to obtain the patient's signature in acknowledgement but was unable to do so as documented below.

Date: _____ Reason: _____

Signature: _____

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SOUTHERN GASTROENTEROLOGY ASSOCIATES

SOUTHERN GASTROENTEROLOGY ENDOSCOPY CENTER

Patient History

Name: _____ Date: _____

Birth Date: _____ Referring Physician: _____

Reason for being here: (Please describe your problem) _____

_____

_____

Past Medical History (Check all that apply)

Have you had the following?	No	Yes	Have you had the following?	No	Yes
Asthma			Liver disease / cirrhosis		
Emphysema / Chronic Bronchitis			Hepatitis		
High blood pressure			Low blood pressure		
Heart failure / heart disease			Rheumatic fever		
Heart attack			Kidney disease		
Heart surgery			Stroke		
Abnormal EKG			Irritable bowel		
Diabetes			Esophageal reflux		
Thyroid disease or goiter			Abnormal chest x-ray		
Cancer			Positive TB test		
Do you use tobacco products? Type How much?			Do you drink alcoholic drinks? How much / how often?		
Have you been addicted to or dependent on any drug?			Have you used cocaine in the last week?		
Do you have any condition / disease that can be transmitted to other people?					
Have you ever had any serious problems with anesthesia?					

Social History Occupation: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other: _____

Children: ( ) Yes ( ) No If "Yes", how many? _____

Person(s) you live with now: _____

Family History Indicate the immediate family members that have any of the following.

Anesthesia Problems _____

Colon Cancer _____

Inflammatory Bowel Disease _____

Liver Disease _____

Review of Systems (Check if present)

Fever		Chest pain		Joint pains		Herpes	
Night sweats		Heart murmur		Broken bones		Anemia	
Weight loss		Irregular heartbeat		Muscle aches		Bleeding problem	
Visual problems		Shortness of breath		Paralysis/ Weakness		Sickle cell	
Dizziness		Cough with blood		Skin rashes		Back problems	
Ringing in ears		Urination problems		Headaches		Sleeping problem	
Hearing loss		Menstrual problems		Black out spells		Neck problem	
Hoarseness		Vaginal discharge		Allergies / Hay fever		Hard contacts	
Nose bleeds		Pregnant		Indigestion		Bridge / crown	
Dry mouth / eyes		Seizures / Epilepsy		Hiatal hernia		Dentures	

What questions do you have for your doctor or anesthetist? _____

_____

_____

Completed by: _____ Relationship _____

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SOUTHERN GASTROENTEROLOGY ASSOCIATES

SOUTHERN GASTROENTEROLOGY ENDOSCOPY CENTER

Medication List / Reconciliation

Name _____ Birthdate _____

Allergies & Reactions _____

Instructions: List all medications taken on a regular basis including over the counter and herbal drugs.

#	Home Medication Name	Dosage	Route	Freq	Last Taken	RN to complete at discharge	
						Continue	Refer to MD*
1						☐	☐
2						☐	☐
3						☐	☐
4						☐	☐
5						☐	☐
6						☐	☐
7						☐	☐
8						☐	☐
9						☐	☐
10						☐	☐
11						☐	☐
12						☐	☐
13						☐	☐
14						☐	☐
15						☐	☐
16						☐	☐
17						☐	☐
18						☐	☐
19						☐	☐
20						☐	☐

New Prescription	Dosage	Route	Frequency	Purpose

I have reviewed this list and understand the medication instructions. I understand that I will receive a copy upon discharge.
* All medications marked as “Refer to MD” will be clarified with the prescribing physician before continuing.

_____ _____

Patient/ Responsible Adult Signature Date

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