GASTROENTEROLOGY ASSOCIATES of Central Virginia

121 Nationwide Drive, Suite A
Lynchburg, VA 24502
Phone: (434)384-1862
Fax: (434)384-7704

Dear Patient:

Please complete this packet to the best of your knowledge, front and back of each page. Once you have completed the packet, return to the above address, and allow 4-6 weeks for the forms to be received and processed.

If you plan to return this paperwork to the office, please sign in and have a seat. You will be called to the receptionist desk in the order you arrived. Thank you.

Patients Full Name: _____Maiden: _____

Preferred Name/Nickname: _____Gender: ☐M ☐F Other: _____

Date of Birth: _____ Marital Status: ☐ Married ☐ Widow ☐ Divorced ☐ Single

Social Security: _____ Language: ☐ English ☐ Spanish ☐ Chinese ☐ Other: _____

Race Type: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify

Mailing Address: _____Apt#_____

City: _____ State/Zip Code: _____

Please check preferred contact number

- ☐ Home phone number: _____
- ☐ Mobile phone number: _____

Email Address: _____

Employer: _____ Number: _____

Family Physician: _____ Number: _____

Referring Physician: _____ Number: _____

Please contact me at the following number to discuss my appointment: _____

****Please complete insurance information on the back****

Insurance Information:

Please take a moment to look at your insurance card and complete the following information:

Please feel free to send copies of Insurance cards, if you do, please make sure to send the front and back of each card.

Primary Insurance Company Name: _____

Insurance Co. Address: _____City/State/Zip_____

Does your card say? (Please check one) ☐ PPO ☐ HMO ☐ POS ☐ PFFS ☐None of these.

Policy Holders Name: _____ DOB: _____

Is there a doctor or physician group listed on your card? If yes, who? _____

Policy / ID Number: _____ Group Number: _____

Secondary Insurance Company Name: _____

Insurance Co. Address: _____City/State/Zip_____

Does your card say? (Please check one) ☐ PPO ☐ HMO ☐ POS ☐ PFFS ☐None of these.

Policy Holders Name: _____ DOB: _____

Is there a doctor or physician group listed on your card? If yes, who? _____

Policy / ID Number: _____ Group Number: _____

******You may need a referral/authorization to be seen by our providers. Please check with your insurance carrier.**

Please make sure that this information is complete and accurate. Incomplete forms may cause delays.

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Upper Endoscopy (EGD)

Patients Full Name: _____

Age: _____ Height: _____ft. ____in. Weight _____lbs.

Referring Doctor: _____Phone: _____

Please check if you are currently experiencing any of the following:

- ☐ Heartburn
- ☐ Gerd (reflux)
- ☐ Nausea
- ☐ Vomiting
- ☐ Weight loss
- ☐ Anorexia
- ☐ Dysphagia (difficulty swallowing)
- ☐ Painful swallowing (Odynophagia)

Medication Information

Allergies to Medications:

- ☐ I have No Known Medication Allergies
- ☐ Yes, I am allergic to Latex!
- ☐ Other medications I am allergic to:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____
5. _____ 9. _____

What is the name of your Pharmacy, Location and Phone Number: _____
_____

Please list all your medications: include the medication, strength, how often you take them, why. List all vitamins, herbals and probiotics (such as Activa and Align).

Medication	Strength	How often you take	Reason for Taking

- ☐ Check here if you have attached added pages necessary to complete medication or allergy sections on these pages. Thank you.

Please check if you have a diagnosis of any of the following conditions:

- ☐ Congestive Heart Failure
- ☐ Angina
- ☐ Oxygen Use
- ☐ Dialysis
- ☐ Kidney Disease
- ☐ Heart Stent placement in the last 12 months
- ☐ Heart Valve replacement (prosthetic)
- ☐ Cardiac defibrillator/Pacemaker
- ☐ Lung Disease (COPD, Emphysema, etc.)
- ☐ Sleep Apnea, if yes: do you use a CPAP/BI-PAP Machine? ☐ CPAP ☐ BI-PAP
- ☐ Watchman/loop valve recorder
- ☐ Head/Neck/Throat Cancers
- ☐ Cirrhosis of the liver
- ☐ Hemophilia (free bleed)
- ☐ Von Willebrand's Disease
- ☐ Other **Bleeding** disorders_____
- ☐ Diabetes
- ☐ High Blood pressure
- ☐ **MRSA** (methicillin resistance staph enterococcus)
- ☐ **VRE** (vancomycin resistance enterococcus)

Are you currently on a prescription **blood thinning medications** such as: Coumadin, Warfarin, Plavix/Clopidogrel, Pradaxa, Eliquis, Effient, Aggrenox, or Xarelto? _____Other? _____. What is the name and number of the doctor/office who prescribed your blood thinner?
Name: _____Number: _____

Are you able to walk unassisted? Please check one	☐ Yes	☐ No		
Do your Require:	☐ Cane	☐ Walker	☐ Wheelchair	☐ Bathroom Assistance

I would prefer my upper endoscopy be scheduled with:
Please check one of the following:

☐ First Available Doctor	☐ Dr. Richards	☐ Dr. Wisniewski
☐ Dr. Clark	☐ Dr. Hou	☐ Dr. Kenny
☐ Dr. Musana	☐ Dr. Bierle-Karnes	☐

I have completed these forms to the best of my knowledge.

Patient Signature: _____Date:_____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I give permission for Gastroenterology Associates of Central Virginia, Inc., to release my protected health information to the individual(s) listed below as described below:

Permission to discuss with:

Name	Relationship	Phone Number	ALL	APPOINTMENTS	TREATMENT	BILLING
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Voice messages may be left (for me) regarding my:

☐ Appointments ☐ Lab Results ☐ Procedure Results ☐ Billing ☐ All

At the following phone number(s): _____ _____

PATIENT RIGHTS:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

* Description of Personal Representative's Authority (attach necessary documentation)

This authorization will remain in effect until I revoke it in writing.

Patient Signature: _____ Date: _____

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Insurance Authorization and Financial Agreement

Gastroenterology Associates currently participates with Piedmont Community Health Plan, Anthem PPO, Anthem HealthKeepers HMO, Aetna, Cigna, and United Healthcare. We also participate in many Medicare and Medicaid products, as well as some other commercial carriers. Please call the number on your insurance card to verify if we are participating in your plan. It is the patients' responsibility to make sure the initial referral to be seen in our office has been arranged through the primary care physician if required by their insurance carrier. ***We will be glad to file any two (2) insurances for you, but you will be responsible for any fees not covered by your insurance plan.

If you have MEDICARE:

I request that payment of authorized Medicare benefits be made to Gastroenterology Associates of Central Virginia, Inc. for any services furnished by one of their Practitioners.
I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Other Insurances:

I agree to be financially responsible for all fees. I authorize the release of any medical information necessary to process any insurance claim(s) and request payment by made directly to Gastroenterology Associates of Central Virginia, Inc.

Collection Fee:

I understand that if my account with Gastroenterology Associates of Central Virginia, Inc. becomes delinquent and is placed in collections, a 25% collection fee will be added to my balance owed.

No Show Fee:

I understand that should I need to cancel or reschedule my appointment; this should be done no later than the day before the appointment. Failure to do so may result in a $50.00 charge.

Included in this packet is a copy of the Gastroenterology Associates of Central VA Notice of Privacy Practices, revised September 12, 2022. I understand that Gastroenterology Associates of Central VA has the right to change its Notice of Privacy Practices from time to time and that I may contact Gastroenterology Associates of Central VA at any time to obtain a current copy of the Notice of Privacy Practices.

I acknowledge that I have read and understand the above items.

Patient Signature: _____ Date: _____

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Privacy Notice

Revised 9/12/2022

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.

If you have any questions about this Notice, please contact our HIPAA Compliance Officer, Michelle Bryant.

We are required by law to maintain the privacy of Protected Health Information ("PHI") and to provide you with notice of our legal duties and privacy practices with respect to PHI. References to Gastroenterology Associates of Central VA, "we," "us," and "our" refer to GACV for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). This center, our employees and workforce members are involved in providing and coordinating health care and are all bound to follow the terms of this Notice of Privacy Practice ("Notice"). We may share PHI between offices for the treatment, payment and helath care operations of the covered entity and as permitted by HIPAA and this Notice.

PHI is information that may identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care products and services to you or payment for such services. This Notice describes how we may use and disclose PHI about you, as well as how you obtain access to such PHI. This Notice also describes your rights with respect to your PHI. We are required by HIPAA to provide this Notice to you.

Gastroenterology Associates of Central Va. Inc. is required to follow the terms of this Notice or any change to it that is in effect. We reserve the right to change our practices and this Notice at any time and to make the new Notice effective for all PHI we maintain. If we do so, the updated Notice will be posted on our website and will be available at our facilities and locations where you receive health care products and services, or summarized at said location. Upon request, we will provide any revised Notice to you.

WHO WILL FOLLOW THIS NOTICE

This notice describes our practice and that of

- Any health care professional authorized to enter information into your office chart;
- All department and units of this facility;
- Any member of a volunteer group we allow to help you while you are at the facility;
- Any medical student, intern, resident or fellow that we allow to help you while you are in the facility;
- Any representative of an insurance carrier, managed care organization, clinical research organization, data analysis organization that is participating in a review of your medical care;
- All employees, staff and other office personnel, and;
- All other entities, sites and locations where the health care professionals in this office practice and follow the terms of this Notice. In addition, these entities, sites and locations may share PHI with each other for treatment, payment or operations purposes as described in this Notice.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

We understand that PHI about you and your health is personal. We are committed to protecting PHI about you. We create a record of the care and services you receive at the endoscopy center. We need this record to provide you with the quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the office. This Notice will tell you about the ways in which may use and disclose PHI about you. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI.

We are required by law to:

- Make sure that PHI that identifies you is kept private, in accordance with applicable law;
- Give you this Notice of our legal duties and privacy practices with respect to PHI about you, and
- Follow the terms of the Notice that is currently in effect

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose PHI. We have provided you with examples in certain categories; however, not every permissible use or disclosure will be listed in this Notice.

Treatment – We may use and disclose your PHI to provide, coordinate and management the treatment, medications and services you receive. For example, we may disclose your PHI to doctors, nurses, technicians, clinical supervisors, or other personnel and team members who are involved in your care. We may also disclose your PHI with other third parties, such as hospitals, and other health care providers, facilities and agencies to facilitate the provision of health care services, medications, and supplies you may need. For example, we may disclose your PHI to a pathologist or laboratory to order a test. This helps to coordinate your care and make sure that everyone who is involved in your care has the information that they need about you to meet your health care needs. Different office locations may share PHI about you in order to coordinate your care. We may also disclose PHI about you to people outside the office who may be involved in your care after you leave the office, such as family members, other physicians involved in your care, or others we use to provide services that are part of your care.

Payment – We may and disclose your PHI in order to obtain payment for the health care products and services that we provide to you and for other payment activities related to the services that we provide. We may use and disclose PHI about you so that treatment and services you receive at our facilities may be billed to and payment may be collected from you, an insurance company or third party. For example, we may need to disclose PHI to your health insurance company to get prior approval for your procedure. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. We may need to give your PHI about the services you received at our facilities so that your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We will bill you or a third-party payor for the cost of health care products and services we provide to you. The information on or accompanying the bill may include information that identifies you, as well as information about the services that were provided to you or the medications you are taking. We may also disclose your PHI to other health care providers or HIPAA covered entities that may need it for their payment activities.

Health Care Operations – We may use and disclose PHI about you for health care operations. These uses and disclosures are necessary for us to perate our health care business and make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine PHI about many office patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurse, technicians, medical students, and other officer personnel for review and learning purposes. We may also combine the PHI we have with PHI from other offices to compare how we are doing and see where we can make improvements in the care and services that we offer. We may review information that identifies you from this set of PHI so others may use it to study health care delivery without learning who the specific patients are.

Appointment Reminders – We may call or write to: remind you of appointments, remind you that it is time to make a routine appointment, remind you of your procedure date, time of arrival and instructions before your procedure. We may send you written correspondence and leave you messages on your answering machine, voicemail, or with an individual that answers the phone if you are not home. We may use and disclose PHI to tell you about potential treatment alternatives, health-related benefits or services that may be of interest to you. We may also disclose PHI in the course of providing feedback regarding questions you asked or test results.

We may also use and disclose your PHI without your prior authorization for the following purposes:

Business Associates – We may contract with third parties to perform certain services for us, such as billing services, copy services or consulting services, among others. These third party service providers, referred to as Business Associates, may need to access your PHI to perform servies for us. They are required by contract and law to protect your PHI and only use and disclose it as necessary to perform their services for us.

As Required By Law – We will disclose your PHI when required to do so by federal, state or local law. We may also make disclosures to the Secretary of the Department of Health and Human Services, if so required.

Individuals Involved in Your Care or Payment of Your Care – We may release PHI about you to a friend, family member, personal representative, or another person who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends about your condition or procedures. Additionally, we may disclose PHI to your “personal representative.” If a person has the authority by law to make health care decisions for you, we will generally regard that person as your “personal representative” and treat him or her the same way we would treat you with respect to your PHI.

To Avert a Serious Threat to Health or Safety – We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Organ and Tissue Donation – If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation to any organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Specified Government Functions – In certain circumstances, federal regulations authorize the facility to use or disclose your PHI to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective service for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

Worker's Compensation – To the extent necessary to comply with law, we may disclose your PHI to worker's compensation or other similar programs established by law.

Public Health Risks – We may disclose your PHI for public health activities to public health or legal authorities charged with preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reactions to medications or problems with products, notifying people of recalls of products, notifying a person who may be exposed to a disease or may be at risk for contracting or spreading a disease or condition, notifying the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. In certain circumstances, we may also report work-related illnesses and injuries to employers for workplace safety purposes.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, credentialing, and licensure, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits, Administrative Proceedings, and Disputes – If you are involved in a lawsuit or dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting part or us, to tell you about the request or to obtain an order protecting the requested information, unless otherwise authorized by law.

Law Enforcement – We may disclose your PHI for law enforcement purposes as required or permitted by law. For example, we may disclose your PHI in response to a subpoena or court order, in response to a request from law enforcement, and to report limited information in certain circumstances.

Coroners, Medical Examiners and Funeral Directors – We may release your PHI to a coroner or medical examiner so that they can carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose your PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Disaster Relief – We may use and disclose your PHI to organizations for purposes of disaster relief efforts.

Food and Drug Administration ("FDA") – We may disclose to persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.

Research – Under certain circumstances, we may use and disclose PHI about you for research purposes. We will almost always ask for your specific information if the research will have access to protected health information and attempt to obtain your authorization. Authorizations for research purposes may be combined with other written permissions and may be for future research studies. We may combine conditioned and unconditioned authorizations for research, provided that the authorization clearly differentiates between the conditioned and unconditioned research components and allows you the option to opt in to the unconditioned research activities.

Victims of Abuse or Neglect – We may disclose PHI about you to a government authority if we reasonably believe you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your PHI to your family member or a close personal friend if it is directly relevant to the person's involvement in your procedure or payment related to your procedure. We can also disclose your PHI in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your PHI as described.

Uses and Disclosures that Require Your Prior Authorization

Specific Uses or Disclosures Requiring Authorization – We will obtain your written authorization for the use or disclosure of psychotherapy notes (if ever received by our office), use or disclosure of PHI for marketing, and for the sale of PHI, except in limited circumstances where applicable law allows such uses or disclosure without your authorization.

Other Uses and Disclosures – We will obtain your written authorization before using or disclosing your PHI for purposes other than those described in this Notice or otherwise permitted by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Rights Regarding PHI:

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy – With few exceptions, you have the right to access and obtain a copy of the PHI that we maintain about you. If we maintain an electronic health record containing your PHI, you have the right to request to obtain the PHI in an electronic format. To inspect or obtain a copy of your PHI, you must send a written request to the Privacy Officer. You may ask us to send a copy of your PHI to other individuals or entities that you designate. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your PHI, you may request that the denial be reviewed. If you request an electronic copy of PHI that is maintained electronically, we will provide you with access to the electronic information in the electronic form and format requested by you, if it is readily producible, or, if not, in a readable electronic form and format as we mutually agree. If we cannot mutually agree on the electronic form and format that we are able to produce, we may provide you with a hard copy or PDF copy. If you request a copy of the information, we may charge a fee as permitted by state law for the costs of copying, mailing or other supplies associates with your request.

Right to Amend – If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the office. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us for an amendment that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the PHI kept by or for the facility;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures – With the exception of certain disclosures, you have a right to receive a list of the disclosures we have made of your PHI, in the six (6) years prior to the date of your request, to entities or individuals other than you. To request an accounting, you must submit a request in writing to the Privacy Officer. Your request must specify a time period.

Right to Request Restrictions on certain uses and disclosures of PHI – You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Officer. We are not required to agree to the restrictions, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you, or a person on your behalf, has paid in full.

Request communications of PHI by alternative means or at alternative locations – You have a right to request that we communicate with you about health matters in a certain way or at a certain location. For instance, you may request that we contact you at a different residence or post office box, or via e-mail or other electronic means. Please note if you choose to receive communications from us via e-mail or other electronic means, those may not be a secure means of communication and your PHI that may be contain in our e-mails to you will not be encrypted. This means that there is a risk that your PHI in the e-mails may be intercepted and read by, or disclosed to, unauthorized third parties. To request confidential communication of your PHI, you must submit a request in writing to the Privacy Officer. Your request must tell us how or where you would like to be contacted. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Rights to a Paper Copy of This Notice – You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy at the site where you obtain health care services from us or by contacting the Privacy Officer. You may obtain a copy of this Notice at our web site. To obtain a paper copy of this Notice, contact an available staff member.

Breach Notification – You have a right to be notified in the event of a breach of your unsecured PHI, and we will notify you in accordance with applicable law.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effected for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the facility. In addition, each time your registered at or are seen at the office for treatment or health care services as an outpatient, you may request a copy of the Notice that is in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted inwriting. To file a complaint with the office, contact:

Michelle Bryant, HIPAA Compliance Officer

121 Nationwide Drive, Lynchburg, VA 24502

(434) 384-1862

You will not be penalized for filing a complaint.

OTHER USES OF PROTECTED HEALTH INFORMATION

Other uses and disclosures of PHI not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.