Please fill out this form and bring it to your appointment.
When printing, select 'fit' or 'fit to page' so all information prints on the page.

Digestive Care Physicians, LLC

PATIENT DATA
FORM MUST BE COMPLETED IN FULL

Today's Date _____

Name _____ Date of Birth _____

Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced Gender ❑ Male ❑ Female

Mailing Address _____
Street Apartment/Unit # City State Zip

Phone Numbers Home _____ Cell _____ Work _____

Primary Phone is ❑ Home ❑ Cell ❑ Work Email Address _____

Preferred Language ❑ English ❑ Arabic ❑ Chinese ❑ French ❑ Hindi ❑ Portuguese ❑ Russian
❑ Spanish ❑ Vietnamese ❑ Unknown ❑ Declined ❑ Other _____

Race ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander
❑ White ❑ Other Race ❑ Unknown ❑ Declined

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Declined

---

Referred to Digestive Care Physicians by _____

Address _____ Phone _____
Street Suite # City State Zip

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you

Name & Relationship _____ Daytime Phone _____

Nearest relative or friend not living with you

Name & Relationship _____ Daytime Phone _____

INSURANCE INFORMATION

Primary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

Secondary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

Tertiary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____
Street Suite # City State Zip

I authorize DCP to communicate electronically with my preferred pharmacy to obtain my prescription history. ❑ Yes ❑ No

---

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of Digestive Care Physicians, LLC and its affiliates. I authorize payment of medical benefits to Digestive Care Physicians, LLC and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient / Guarantor Signature* _____ Date _____

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

Digestive Care Physicians, LLC

PatientTips

Welcome to Digestive Care Physicians

At Digestive Care Physicians, our highly trained physicians and staff are dedicated to providing you with the best possible care in a comfortable, compassionate setting. Whether you are coming in for an appointment or a procedure, the information in this brochure will help make your visit go more smoothly. Please take a moment to read it carefully. Should you have questions, any member of our staff will be glad to help you.

SCHEDULING APPOINTMENTS

Digestive Care Physicians has multiple offices and an endoscopy center north of Atlanta. This enables us to offer appointments that are convenient and fit your schedule.

When you call to schedule an appointment, please have your personal calendar on-hand. This will help avoid scheduling conflicts and possible cancellations.

MISSED APPOINTMENT POLICY

If you are unable to keep your appointment, please reschedule at least 24 hours in advance. Our missed appointment policy is as follows:

Office Visit – $25

Procedures – $75

PATIENT INFORMATION

- Remember to bring a photo I.D. and your most current insurance card(s).
- Please arrive early, allowing ample time for traffic, parking and completing any necessary paperwork.
  - New patients – 30 minutes
  - Established patients – 15 minutes
  - Procedures – 45 minutes
- Please bring all test results, lab work, X-rays, etc., that pertain to the reason for your visit. If you do not have these documents, please make sure they are mailed or faxed to your Digestive Care Physicians provider's location prior to your appointment.

INSURANCE INFORMATION

- Digestive Care Physicians participates in most health plans; however you should know the following about your specific plan:
  - If the physician and facility are in-network
  - If the physician is at your preferred tier level
  - Your annual deductible
  - Your office visit co-payment
  - If a referral is required
- Coordinate all required referrals with your primary care physician and submit to your AGA physician at least 48 hours prior to your scheduled appointment.
- Digestive Care Physicians will submit primary, secondary and tertiary claims on your behalf as long as the information needed to process the claim is obtained and verified *before* your visit. If this information is obtained *after* your visit, the patient or guarantor is responsible for the balance.
- Digestive Care Physicians accepts Medicare, Medicaid and most insurances offered in Georgia.

PAYMENT

- Payment is expected at the time of service. This applies to all co-payments, co-insurance and/or deductibles based on your insurance plan.
- We accept cash, checks and all major credit cards.
- A $30 fee will be incurred for returned checks.
- Payment plans can be arranged with a Financial Counselor.

OFFICE HOURS

8 AM to 5 PM Monday through Thursday
8 AM to 3 PM Friday
Physicians on call 24 hours-a-day, 7 days-a-week

www.digestivecarephysicians.com

Digestive Care Physicians, LLC

Understanding YOUR Insurance Plan

Thank you for choosing Digestive Care Physicians (DCP) for your healthcare needs. We value each of our patients and aim to offer you the best possible medical care, in addition to keeping you informed about your healthcare services.

As a courtesy, our financial counselor will contact your insurance company through an electronic verification system to confirm your insurance benefits. Unfortunately, this system does limit the information DCP can obtain on your behalf to only your insurance effective dates and the amount due at the time of service (co-pay).

Because each health insurance plan is different, we recommend that you contact your insurance company to better understand your unique benefits and plan requirements. This guide will help you through any insurance-related steps you may need to take prior to your office visit or procedure.

You are scheduled to visit our office.

What to do before your visit?

Remember, Digestive Care Physicians (DCP) is considered a *specialist*.

Patient's Responsibility

Prior to your office visit, contact your insurance company to ask or verify the following information:

- Is your DCP physician *in-network* or considered *out-of-network*?
- Does your plan require a *referral* from your primary care physician? If so, verify it was sent to our office.
- What is your *co-payment* amount for a *specialist* ? This amount may be different than your primary care physician.
- Do you have an out-of-pocket *deductible*?
- Does your plan have a *co-insurance* amount?
- Before you end the call, obtain a *reference number.*

DCP's Responsibility

As a courtesy, DCP will contact your insurance company to verify benefits, but is limited to:

- > Effective dates of coverage
- > Amount due at the time of service (co-pay/co-insurance)
- > DCP is not able to verify if our physician is in-network or out-of-network for your unique insurance plan.
- If a referral is received, DCP 's staff will file the referral in your medical record.

Questions:
If you have any questions, please call your DCP office and ask to speak with the financial counselor.

DEFINITIONS

Co-insurance – A set percentage you pay for covered healthcare expenses to share the cost with your insurance company; typically paid after an annual deductible is met.

Co-payment – A set fee you pay for a covered healthcare service that is collected at the time of service.

Deductible – Amount of expenses that must be paid out-of-pocket before an insurer will pay.

Facility – Where the procedure will be performed. Procedures offered by DCP may be performed in one of our accredited endoscopy centers, DCP office, or hospital. Typically, the out-of-pocket amount is less at our endoscopy centers.

In-network – Healthcare providers and facilities that contract with your insurance company at a preferred rate.

Out-of-network – Healthcare providers and facilities that do not contract with your insurance company.

Reference Number – A number given to reference a call made to your insurance company to verify benefits. This number will help to resolve an issue if there is a discrepancy involving payment of service.

Referral – An order from a primary care physician for a patient to see a specialist.

Specialist – A physician who focuses on a specific area of medicine.

Please fill out this form and bring it to your appointment.
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Digestive Care Physicians, LLC

PERSONAL HISTORY

Today's Date _____

Name _____ Age _____ Date of Birth _____

Referred by _____ Primary Care Physician _____

Other physicians involved in your healthcare _____

Describe the reason(s) for your visit _____

1) PATIENT MEDICAL HISTORY Check all that apply.

- ❑ **Cirrhosis**
- ❑ **Colon Cancer**
- ❑ **Colon Polyps**
- ❑ **Crohn's Disease**
- ❑ **Diverticulosis**
- ❑ **End Stage Renal Disease (ESRD)**
- ❑ **GERD**
- ❑ **Hepatitis B**
- ❑ **Hepatitis C (HCV)**
- ❑ **Irritable Bowel Syndrome**
- ❑ **Liver Disease**
- ❑ **Stomach/Intestinal Ulcers**
- ❑ **Ulcerative Colitis**
- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Arthritis/Osteoarthritis
- ❑ Asthma
- ❑ Cancer: Type _____
- ❑ Chronic Kidney Disease (CKD)
- ❑ Congestive Heart Disease (CHF)
- ❑ COPD/Emphysema
- ❑ Coronary Artery Disease (CAD)
- ❑ Diabetes
- ❑ HIV/AIDS
- ❑ Hyperlipidemia/High Cholesterol (HLD)
- ❑ Hypertension
- ❑ Hypothyroidism
- ❑ Myocardial Infarction/ Heart Attack
- ❑ Nerve/Muscle Disease
- ❑ Osteoporosis
- ❑ Pancreatitis
- ❑ Seizures
- ❑ Stroke (CVA)
- ❑ Other _____

2) VACCINES

Have you ever had a Pneumococcal (Pneumonia) Vaccine? ❑ Yes ❑ No

Have you ever had any of the following vaccines? ❑ Influenza (Flu) ❑ Hepatitis A ❑ Hepatitis B

❑ Other _____

3) SURGICAL HISTORY

Check all that apply and provide dates.

- ❑ **Colon Surgery** _____
- ❑ **Colonoscopy** _____
- ❑ **Hemorrhoid Surgery** _____
- ❑ **Gallbladder Surgery** _____
- ❑ **Gastric Surgery** _____
- ❑ **Liver Surgery** _____
- ❑ **Small Intestine Surgery** _____
- ❑ Appendectomy _____
- ❑ Breast Surgery _____
- ❑ C-Section _____
- ❑ CABG/Heart Surgery _____
- ❑ Defibrillator _____
- ❑ Fracture Surgery _____
- ❑ Hernia Surgery _____
- ❑ Hysterectomy _____
  - Abdominal _____
  - Vaginal _____
- ❑ Laparotomy _____
- ❑ Obesity Surgery _____
  - Type, if known _____
- ❑ Pacemaker _____
- ❑ Prostate Surgery _____
- ❑ Spinal Surgery _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Transplant Surgery _____
- ❑ Tubal Ligation _____
- ❑ Valve Replacement Surgery _____
- ❑ Other _____

Name _____ Date of Birth _____

4) MEDICATIONS

List Current Medications (including herbal) and Dosage

_____

_____

_____

_____

_____

List Current Medications (including herbal) and Dosage

_____

_____

_____

_____

_____

Are you currently taking any blood thinners? ❑ Coumadin ❑ Plavix ❑ Warfarin ❑ Xarelto ❑ Other _____

Are you currently taking any of the following aspirin/NSAIDs? ❑ Advil ❑ Aleve ❑ BC Powder ❑ Goody's Powder ❑ Ibuprofen ❑ Naprosyn

5) ALLERGIES

List any medication allergies. ❑ No known medication allergies

_____

List any environmental or food allergies. ❑ No known enviromnental allergies ❑ No known food allergies

_____

6) FAMILY HISTORY (1ST degree relatives) Check all that apply.

	Mother	Father	Sister	Brother	Son	Daughter	Age at diagnosis (if known)
Colon Polyps	❑	❑	❑	❑	❑	❑	_____
Crohn's Disease	❑	❑	❑	❑	❑	❑	_____
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	_____
Cancers							
Breast	❑	❑	❑	❑	❑	❑	_____
Colon	❑	❑	❑	❑	❑	❑	_____
Esophagus	❑	❑	❑	❑	❑	❑	_____
Lung	❑	❑	❑	❑	❑	❑	_____
Lynch Specific (uterine, bladder or ureter)	❑	❑	❑	❑	❑	❑	_____
Pancreas	❑	❑	❑	❑	❑	❑	_____
Prostate		❑		❑	❑		_____
Stomach	❑	❑	❑	❑	❑	❑	_____
Other _____	❑	❑	❑	❑	❑	❑	_____
Liver Disease	❑	❑	❑	❑	❑	❑	_____
Diabetes	❑	❑	❑	❑	❑	❑	_____
Heart Disease/Coronary Artery Disease	❑	❑	❑	❑	❑	❑	_____

7) SOCIAL HISTORY

Provide details regarding current and/or past use of the following:

Alcohol (beer, wine, liquor)	❑ Never	❑ Former	❑ Current (Every Day)	❑ Current (Some Days)	❑ Current (Unknown)
I.V. or Recreational Drugs	❑ Never	❑ Former	❑ Current (Every Day)	❑ Current (Some Days)	❑ Current (Unknown)
Tobacco (cigarettes, cigars, chewing tobacco)	❑ Never	❑ Former	❑ Current (Every Day)	❑ Current (Some Days)	❑ Current (Unknown)

Name _____ Date of Birth _____

8) SYSTEMS REVIEW
Are you experiencing any of the following?

ALLERGY/IMMUNOLOGY
- ❑ Seasonal Allergies
- ❑ None of the Above

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Leaky Heart Valves
- ❑ Heart Murmur
- ❑ Heart Racing/Skipping
- ❑ Palpitations
- ❑ None of the Above

CONSTITUTIONAL
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Malaise (feeling ill)
- ❑ Weight Gain
- ❑ Weight Loss (dieting)
- ❑ None of the Above

EYES
- ❑ Blurred Vision
- ❑ Visual Changes
- ❑ None of the Above

EARS/NOSE/THROAT
- ❑ Mouth Ulcers/Sores
- ❑ Nose Bleeds
- ❑ None of the Above

ENDOCRINE
- ❑ Bruise easily
- ❑ Excessive Thirst
- ❑ Heat/Cold Intolerance
- ❑ History of High or Low Blood Sugar
- ❑ None of the Above

GASTROINTESTINAL
- ❑ Abdominal Pain/Discomfort
- ❑ Anal/Rectal Pain or Itching
- ❑ Black Stool
- ❑ Bloating/Belching/Gaseousness
- ❑ Change of Bowel Habit
- ❑ Constipation
- ❑ Diarrhea/Loose/Watery Stool
- ❑ Difficulty in Swallowing
- ❑ Fecal Incontinence
- ❑ Heartburn/Esophageal Reflux
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Mucus in Stool
- ❑ Nausea/Vomiting
- ❑ Rectal Bleeding (in stool, commode, toilet paper)
- ❑ Urges to have Bowel Movements
- ❑ None of the Above

GENITOURINARY
- ❑ Are you pregnant?
- ❑ Date of last period _____
- ❑ Blood in Urine
- ❑ Burning/Pain with Urination
- ❑ Increased Frequency/During Night
- ❑ Kidney Stones
- ❑ Recent/Frequent Urinary Tract Infection
- ❑ Urges to Urinate
- ❑ Urinary Incontinence
- ❑ None of the Above

HEMATOLOGY/LYMPHATIC
- ❑ Bleeding Problems
- ❑ Enlarged Nodes/Swollen Glands
- ❑ Excessive Bruising
- ❑ History of Anemia
- ❑ None of the Above

MUSCULOSKELETAL
- ❑ Back Pain
- ❑ Joint Pain/Arthritis
- ❑ None of the Above

NEUROLOGIC
- ❑ Headaches
- ❑ Dizziness/Vertigo
- ❑ Recent Numbness/Weakness
- ❑ Seizures
- ❑ None of the Above

PSYCHIATRY
- ❑ Anxiety
- ❑ Changes in Sleep Pattern
- ❑ Depression
- ❑ Loss of memory
- ❑ None of the Above

RESPIRATORY
- ❑ Chronic Cough
- ❑ Shortness of Breath
- ❑ Wheezing or Asthma Symptoms
- ❑ None of the Above

SKIN
- ❑ Jaundice (yellow eyes or skin)
- ❑ Rashes, Bumps or Sores
- ❑ None of the Above

OTHER _____

_____

_____

_____

_____

❑ All Others Negative

Patient Signature _____ Date _____

My signature below confirms I have reviewed the above with the patient/family.

Physician Signature _____ Date _____

Please fill out this form and bring it to your appointment.
When printing, select 'fit' or 'fit to page' so all information prints on the page.

Digestive Care Physicians, LLC

FINANCIAL DISCLOSURE STATEMENT

Date _____

Patient Name _____ Date of Birth _____
(please print)

Thank you for choosing Digestive Care Physicians, LLC, a division of AGA, LLC. Please read and sign this Financial Disclosure Statement prior to your appointment. Patients who do not pay in full at the time of service must complete the required information and insurance forms before service will be rendered.

You can expect to receive the following bills as a result of your visit:

- **Physician Fee:** Fee to be paid to the physician for performing the service. This bill will be from AGA, LLC, AGA Clinical Services, LLC, or AGA Professional Services, LLC.
- **Lab Fee:** If a lab test is ordered, a second bill will come from a lab or a radiologist.

Some insurance companies require precertification for this service. We will make every effort to verify your benefits and obtain any necessary precertification prior to your appointment. This is not a guarantee of payment.

Your insurance company will send you an Explanation of Benefits that will explain how your bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand your insurance benefits.

Some insurance plans require you to pay different out-of-pocket amounts based on the location where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. We will submit primary, secondary and tertiary claims on your behalf as long as the information needed to process the claim is obtained and verified before your visit. If this information is obtained after your visit or if the information provided is deemed inactive for your dates of service, the patient or guarantor is responsible for the balance.

We accept cash, checks and major credit cards. We collect co-payments at the time of service. Additional payment may be required based on your insurance plan. If you have a balance due at any affiliate of AGA, LLC, including AGA Clinical Services, LLC or AGA Professional Services, LLC, your payment will be applied to the oldest balance first. In the event your account has a credit for one affiliate and a deficit for another, we reserve the right to transfer credits to any outstanding balances prior to issuing a refund.

Additional questions regarding billing or payment arrangements should be directed as follows:

- **For an upcoming visit**, call the office where your appointment is scheduled and ask to speak to the financial counselor.
- **For previous visits,** call 678.223.7788.

If you are unable to keep your appointment, please reschedule at least 48 hours in advance. A missed appointment will result in a $25 fee. A $30 fee will be incurred for returned checks.

PATIENT'S REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices of AGA, LLC and its affiliates and that I may receive multiple bills related to my service as explained above. I authorize payment of medical benefits to AGA, LLC and its affiliates and authorize them to release any medical information necessary to process claims. I give AGA, LLC permission to apply payments received to balances due at AGA, LLC, or any of its affiliates, including AGA Clinical Services, LLC or AGA Professional Services, LLC, and understand that payments will be applied to the oldest balance first. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan.

_____ Date _____

*Patient /Authorized Representative Signature ** If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

Digestive Care Physicians, LLC

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.

Digestive Care Physicians, LLC and Digestive Care Endoscopy, LLC divisions of AGA, LLC and its affiliates ("the Practice"), present this Notice of Privacy Practices ("Notice") to our patients describing how your identifiable medical information (called protected health information or PHI) may be used or disclosed, and to notify you of your rights regarding this information.

Patient Protected Health Information

Under Federal law, your patient health information is protected and confidential. Protected health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Protected Health Information

The Practice uses health information about you for treatment, analyzing procedures and lab results. We also use PHI to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances where the law applies, we may be required to use or disclose the information without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: The Practice will use and disclose your PHI to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your medical record and use it to determine the most appropriate course of care. The Practice may also disclose this information by fax, in person, or via telecommunication. We may communicate to other health care providers who are participating in your treatment, to pharmacists who are filling and refilling your prescriptions, and to family members who are helping with your care.

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

Health Care Operations: The Practice will use and disclose your health information to conduct our standard internal operations. Examples include proper administration of records, evaluation of the quality of treatment, and assessing the care and outcomes of your case and others like it.

Release of Information to Family or Friends

The Practice knows that family or friends are an integral part of a patient's care. If you wish to authorize a family member or friend to receive or request information regarding your care or test results, please provide their name and contact information on the 'Notice of Privacy Practices Acknowledgement' form. The Practice will not release your information to any friend or family without your written consent. If you wish to change or update the authorized individuals, you will need to make these updates in writing.

Special Uses

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

Health Information Exchange

Your information may be shared with other healthcare providers via Health Information Exchange (HIE).

- **Function of the HIE**
  The function of the HIE is to improve patient-centered healthcare through the use and exchange of electronic health information. This collaborative effort seeks to close the patient information gap by allowing authorized healthcare providers to share their patients' records on an as-needed basis to support improved quality of care and patient health outcomes, as well as reduce patient healthcare costs.

- **Types of Data Exchanged**
  Members of the HIE share electronic health records, which may include your medical history, allergies, radiology, labs, doctors' notes and/or immunizations. Sensitive information that requires specific written authorization to disclose will not be shared through the HIE; this includes mental health and psychotherapy records. If you want this type of sensitive information shared, an express written consent will be required for each release. However, sensitive health information, including, but not limited to: substance abuse records, HIV/AIDS information, genetic testing, and developmental disability records may be viewed through the HIE unless you opt-out of the HIE (See "Opting Out" section).

- **Permitted Disclosures**
  The HIE ensures protection of patients' personal information by limiting use of patient health data to ensure meaningful use, as described in the "How We Use Protected Health Information" section of this document. In addition, state agencies may only request, receive, use and disclose patient health data solely as authorized by applicable law, or as legally authorized by the individual.

- **Opting Out**
  You have the choice to opt-out of having your electronic records viewed by participating members of the HIE at any time, by completing the opt-out form, which will be provided upon request. If you choose to opt-out of the HIE, your electronic health records cannot be viewed or shared with other healthcare providers using the network. However, authorized healthcare providers will still be able to access your health information on an as-needed basis to assist with continued care via phone, fax, and/or regular mail. Until you submit a completed opt-out form, or provide written notice that you are opting not to participate in the HIE, your electronic information is subject to be viewed amongst authorized members of the HIE utilizing the system. Once received, it may take up to five business days to process the request. It is important to note that if another provider who treats you is a member of the HIE, if you do not opt-out with that provider, your information may still be viewed and shared via the HIE.

- **Opting Back In**
  If you choose to have your electronic records viewed by participating members of the HIE after opting out, you may simply choose to opt-out at any time by providing a written request. It is important to note that if you choose to opt-out of having your electronic records shared via the HIE, none of your electronic records will be viewable via the HIE until you provide the Practice written notification expressly consenting to your electronic records being shared via this method.

- **Potential Risks and Benefits of HIE Participation**
  - **Benefits**
    Participation provides patients with several benefits, including: quick, secure and accurate sharing of patient information among authorized healthcare providers for improved and efficient patient care; reduction of duplicate medical tests; expedited information retrieval, increasing patients' face-to-face time with providers; and enhancing accuracy and efficiency in patient care.

  - **Risks**
    There are limited risks associated with your participation in the HIE. The risks are managed through HIE policies and federal HIPAA regulations, by which all participants must abide. You have a right to receive a list of occurrences that your health information was accessed, as well as for what purpose, as described in the "Accounting of Disclosures" section of this document. In the event there is a breach of security which involves your health information, you will be notified per HIPAA regulations.

Other Uses and Disclosures Not Requiring Written Permission

The Practice may use or disclose your protected health information for other reasons, even without your consent. Subject to certain requirements, the Practice is permitted to give out health information without your permission for the following purposes:

- **Required by Law**
  The Practice may be required by the law to disclose your PHI for certain purposes, such as reporting gunshot wounds, suspected abuse or neglect, or similar injuries and events.

- **Research**
  The Practice may use or disclose information for approved medical research subject to specific criteria.

- **Public Health Activities**
  As required by law, the Practice may disclose vital statistics, diseases, proof of immunization, information related to recalls of dangerous products, and similar information to public health authorities.

- **Health Oversight**
  The Practice may be required to disclose information to assist in investigations and audits; eligibility for government programs; inspections; licensure or disciplinary actions; compliance to civil rights laws; and similar activities.

- **Judicial and Administrative Proceedings**
  The Practice may disclose information in response to an appropriate subpoena or court order.

- **Law Enforcement Purposes**
  Subject to certain restrictions, the Practice may disclose information required by law enforcement officials.

- **Deaths**
  We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

- **Serious Threat to Health or Safety**
  The Practice may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Military and Special Government Functions**
  If you are a member of the armed forces, the Practice may release information as required by military command authorities. The Practice may also disclose information to correctional institutions or for national security purposes.

- **Workers' Compensation**
  The Practice may release information about you as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights regarding your health information. Submit any concerns in writing to the Practice's Compliance Officer (see below).

- **Request Restrictions**
  You may request restrictions on certain uses and disclosures of your health information. These requests must be in writing. the Practice is not required to agree to most restrictions, but if we do agree, we abide by those restrictions.

- **Restrict Disclosure to a Health Plan**
  You may request, in writing, to restrict disclosure of your PHI to a health plan. For example, you may request in writing that you choose not to use your insurance for a specific visit. If the request is made in writing in advance, the healthcare service or item is paid in full at the time of service, and the disclosure is for payment or healthcare operations, the Practice must agree to the restriction except for cases where the disclosure is required by law. (i.e., your health plan requires all healthcare services to be disclosed or filed.)

- **Confidential Communications**
  You may ask us to communicate with you confidentially including by reasonable alternate means or locations. This request must be made in writing. There may be conditions placed on accommodating the request in certain situations.

- **Inspect and Obtain Copies**
  You have the right to see or receive a copy of your health information. There may be a small charge dictated by Georgia Law for these copies. You may obtain a copy of your health information by completing and submitting a medical records release form. By law, you must receive the requested information within 30 days.

- **Amend Information**
  If you believe information in your record is incorrect, you have the right to request that the Practice correct or amend the existing information. The request must be made in writing and include a reason to support the requested amendment. Your Practice physician has the right to refuse your request. Regardless, a letter concerning your request will be sent within 60 days of said request.

- **Accounting of Disclosures**
  You may request a list of instances where we have disclosed health information about you within the last six years for reasons other than treatment, payment, or health care operations. This request must be submitted in writing. The request must be fulfilled within 60 days. If the Practice is unable to fulfill the request within 60 days, the law grants a one-time 30 day extension. A written statement regarding the reason for the delay will be provided to you. If you request an accounting more than once in a 12 month period, the Practice may impose a reasonable cost-based fee for each subsequent request.

- **Obtain Paper Copy of Notice**
  If you have previously received this Notice in electronic form, you have the right to request a paper copy of this Notice.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We are also required by law to notify you in the event of a breach of your unsecured PHI.

Changes in Privacy Practices

We may change our policies at any time. A current version of our Notice is available on the Practice's website. A current summary version of our Notice is always available in each waiting area. You may also request a copy of the current version of our Notice at any time. Any changes to our privacy practices described in this Notice will apply to all PHI created or received prior to this revision. For more information about our privacy practices, submit concerns in writing to the Practice's Compliance Officer (see below).

Complaints

If you are concerned that we have violated your privacy rights, if you disagree with a decision we made about your records, or would like to file a complaint, contact the person listed below. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

If you have any questions, requests, or complaints regarding privacy rights, please contact the Practice's Compliance Officer:

Mailing Address:
United Digestive
ATTN: Compliance Officer
550 Peachtree St NE, Suite 1600
Atlanta, GA 30308

Phone: 404.888.7575
Email: compliance@uniteddigestive.com

Please fill out this form and bring it to your appointment.
When printing, select 'fit' or 'fit to page' so all information prints on the page.

Digestive Care Physicians, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Digestive Care Physicians, LLC and Digestive Care Endoscopy, LLC, divisions of AGA, LLC and its affiliates ("the Practice"), has given me the opportunity to read a detailed notice of their Privacy Practices.

CONSENT TO COMMUNICATE WITH YOU

❑ I authorize the Practice to leave results or protected health information on my voicemail. ❑ Home ❑ Cell ❑ Work

While the Practice takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication. **You may use the Practice's Patient Portal to securely communicate with your provider.**

❑ I authorize my physician and/or his/her representative to correspond with me via email regarding medical care if I initiate the email contact. The email address being authorized is: _____

CONSENT TO COMMUNICATE WITH OTHERS

❑ I **do not** authorize the Practice to communicate with anyone other than me, excluding all disclosures allowed by law.

❑ I authorize representatives from the Practice to share information regarding care or tests results with the individuals listed below if I cannot be reached. These individuals may also request protected health information on my behalf.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I recognize that the Practice may share my protected health information with other healthcare providers, including sensitive health information such as: HIV/AIDS information, substance abuse records, genetic testing information, and developmental disability records. This information may be shared with other healthcare providers via various methods, including but not limited to, fax or health information exchange.

NOTE: If you want to opt out of having your information shared via health information exchange, you must request and complete an Opt-Out Form available at our offices.

_____ Date _____

Patient/Authorized Representative Signature ** If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

FOR OFFICE USE ONLY

If patient does not sign this form, please provide a reason why the acknowledgement was not obtained and witness.

_____

Reason(s)

_____ Date _____

Witness / Staff Signature