

GI OF NORMAN, LLC

PATIENT INFORMATION SHEET

Age _____ Date _____

Name _____ Birth Date _____

Last First Middle Initial

Address _____ Zip _____
Street City

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

My Primary Contact Phone Number is my: Home Work Cell

Social Security _____ Occupation _____ Sex _____ Marital Status _____

Employer _____ Employer's Address _____

Spouse or Parent's Name _____ Work Phone (____) _____

Responsible Party _____ Relationship _____

Referring Dr. _____ Referring Dr. Phone (____) _____

In case of emergency, who should be notified? _____ Ph (____) _____

(Other Than Spouse)

INSURANCE INFORMATION

Primary Insurance _____	Secondary Insurance _____
Insured's Name _____	Insured's Name _____
Insured's SSN _____	Insured's SSN _____
Insured's Birth Date _____	Insured's Birth Date _____
Employer _____	Employer _____

FINANCIAL

Payment is expected at the time services are rendered. If insurance is applicable, you will be responsible for coinsurance or office visit co-pay. Charges vary according to the type and extent of service. Insurance is a contract between you and your insurance company. We will be happy to file your insurance claim, if provided with a copy of your card, but any dispute regarding coverage is your responsibility to resolve.

I hereby give permission to Dr. Philip C. Bird, Dr. Steve K. Arora, Dr. Chintan A. Parikh, Dr. Andrew W. Black or Cindy Kirkland, ARNP-C, to evaluate and administer treatment, and perform such minor procedures that may be deemed necessary in the diagnosis and/or treatment of my medical condition. I also understand that I am financially responsible for any fee incurred. A \$25.00 charge may be assessed on returned checks. I also authorize the payment of medical benefits directly to my physician.

Signed _____ Date _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how my medical information will be used and disclosed by GI of Norman, LLC is in the "Notice of Privacy Practices", which I should read before signing this agreement. A copy has been provided and is posted in the clinical site.

I have received and accepted a copy of GI of Norman, LLC's "Notice of Privacy Practices." YES NO
Reason for refusal, if "No" _____

Signed _____ Date _____

QUESTIONNAIRE

Patient Name: _____ Date: _____

Referring Doctor: _____

Chief Complaint: _____

Y	N		Y	N	
___	___	Greater than 10 lb. change in last 2 years?	___	___	Recent joint changes?
___	___	Fever over 100 degrees in last 2 weeks?	___	___	Difficulty walking?
___	___	Any loss of sensation?	___	___	Prolonged bleeding?
___	___	Change in balance?	___	___	Swelling in neck or groin?
___	___	Double vision?	___	___	Skin rash?
___	___	Visual loss in last 6 months?	___	___	Excessive itching?
___	___	Unusual throat pain/soreness?	___	___	Mood swings?
___	___	Ear pain or drainage?	___	___	Do you cry easily?
___	___	Chest pain on exertion?	___	___	Excess anger?
___	___	Heart palpitations/racing?	___	___	Insomnia?
___	___	Shortness of breath at rest?	___	___	Do you feel depressed?
___	___	Cough with sputum-yellow or clear?	___	___	More irritable than usual?
___	___	Difficulty urinating?	___	___	Family history of colon cancer?
___	___	Burning with urination?	___	___	Change in marital status?
___	___	1. Have you had continuous or repeated discomfort or pain in your lower abdomen over the past three months? (If no, please skip to #2)			
___	___	a. Is this discomfort or pain relieved by a bowel movement?			
___	___	b. Is this discomfort or pain associated with a change in the frequency of bowel movement (i.e., having more or fewer bowel movements)?			
___	___	c. Is this discomfort or pain associated with a change in the consistency of the stool (i.e., softer or harder)?			
___	___	2. Would you say that at least one fourth (1/4) of the occasions or days in the last three months you have had any of the following?			
___	___	a. Fewer than three bowel movements A WEEK (0-2)			
___	___	b. More than three bowel movements A DAY (4 or more)			
___	___	c. Hard or lumpy stools			
___	___	d. Loose or watery stools			
___	___	e. Straining during a bowel movement			
___	___	f. Urgency - having to rush to the bathroom for a bowel movement			
___	___	g. Feeling of incomplete bowel movement			
___	___	h. Passing mucus (white material) during a bowel movement			
___	___	i. Abdominal fullness, bloating or swelling			

Drug Allergies: _____

Past Medical History: _____

Surgeries/Procedures: _____

Family History (age and health status, if deceased, give cause of death):

Father: _____

Mother: _____

Brother/Sister: _____

Social History:

Marital Status: _____ Number of Children: _____

Last Grade Completed: _____ Occupation: _____

Habit History:

Smoking: Yes / No Number of years smoked / quit: _____

Circle: Cigarettes / Cigars / Pipes Number per day / week: _____

Alcohol: Yes / No Drinks per day / week: _____

Tea (Hot/Cold) _____ /day Sodas _____ oz./day Coffee _____ Cups/day

Physician Signature _____

GI of Norman, LLC, 1125 N. Porter, Ste. 301 Norman OK, 73071

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOS INFORMATION WILL BE SHARED)

Name	Date of Birth	
Address	City	
()		
Telephone Number	State	Zip

II. SCOPE AND PURPOSE FOR SHARING INFORMATION

I understand that protected health information is health that identifies me. The purpose of this authorization is to allow GI of Norman LLC to share my protected health information.

III. AUTHORIZATION AND INFORMATION TO BE SHARED

I authorize GI of Norman LLC as set forth below, to share my protected health information for reasons *in addition to those already permitted by law (which includes spouse, personnel involved in the treatment and continuum of my care, medical operations and payment for services).*

A. Persons/Organizations Authorized to Receive my Information:

(Name, Address, Phone, and Fax)	Relationship	Purpose

B. Information shared:

1. Check one or more boxes below:

- | | | |
|--|---|---|
| <input type="checkbox"/> Entire Medical Record (includes all records except Psychotherapy Notes) | <input type="checkbox"/> Laboratory Report(s) | <input type="checkbox"/> Operation Report(s) |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Radiology Films | <input type="checkbox"/> Alcohol/Drug use Records |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Report(s) | <input type="checkbox"/> EKG Report(s) |
| <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Operation Report(s) | <input type="checkbox"/> Physician's Orders |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other |
| <input type="checkbox"/> Consultation Report(s) | | |

2. Converging Services Between _____ and _____ (Insert either date(s) or "ALL")

IV. EXPIRATION AND REVOCATION:

A. This Authorization Will Expire (must choose one):

- 3 years after last office encounter Other (Insert date(s) or "event"): _____

B. Right to Revoke

I understand that I may change this authorization at anytime by writing to the addresses listed at the top of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

v. ACKNOWLEDGEMENTS AND SIGNATURES

A. Acknowledgements

- I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment claims.
- If checked and initialed, GI of Norman is authorized to share my protected health information for the purpose of marketing. I understand GI of Norman may receive either direct or indirect compensation for sharing my information _____.
- I understand I may inspect or obtain a copy of the health information shared under this authorization by sending a written request to the address listed at the top of the form.
- I understand GI of Norman LLC, as a member of the Oklahoma Physician Health Exchange (OPHX) may utilize an electronic network to exchange my protected health information with other providers unless I choose not to participate.
- I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. Signature This document must be signed by the individual or the individual's legal representative.

- Signature (Patient or Legal Representative) Date

Printed Patient or Legal Representative Name	Capacity of Legal Representative (if applicable)
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OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI) PATIENT INSTRUCTIONS

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Write your name, date of birth, complete address, area code and telephone number in the spaces provided.

II. SCOPE & PURPOSE FOR SHARING INFORMATION

This section explains what protected health information is and lets you know that you are allowing your protected health information to be shared with the person (s) you name in Section III A.

III. AUTHORIZATION & INFORMATION TO BE SHARED

In most cases, your protected health information can be shared for treatment, payment, and healthcare activities under the Health Insurance Portability Authorization Act (HIPAA). For reasons in addition to permitted treatment, payment, and healthcare activities, you must complete Sections III A & B as follows:

A. Person/Organization Receiving Information and Purpose for Sharing

Write the person/organization's name you wish to share information with, their address, phone number and fax number, their relationship to you (example: lawyer, family member, etc.), and the purpose for which you wish to share the information. **If you write more than one person/organization in this section, the information you check in Section B will be shared with everyone listed.**

B. (1) This section lists what information you want to share. You can check one or more boxes, **unless** you are sharing psychotherapy notes. If you are sharing psychotherapy notes, you can only check that box and no others.

(2) List the dates of service for the information you want to share (if you don't know the exact dates, try to at least give the month and year), or you can choose to share all your records by writing the word "all".

IV. EXPIRATION & REVOCATION

A. Expiration

By law, your permission to share information can only last for a certain amount of time. You must check one box.

B. Right to Revoke

You can change your mind about sharing this information at any time. If you change your mind, you must write to the address listed at the bottom of this form and ask that your information no longer be shared. Information may already have been shared before your written request is received.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. This section explains that you voluntarily signed the form and that you can't be denied eligibility for benefits, treatment, enrollment, or payment of claims if you don't sign the form.

2. If you check the box and write your initials in this section, you are agreeing to share your protected health information for marketing purposes. The person/company asking you to sign the form may receive some sort of payment for your information.

3. If you give permission to share your protected health information with someone who is not a health plan or health care provider, (family member, etc) privacy regulations may no longer protect the information.

4. You may look at or get a copy of the protected health information shared under this form by writing to the address listed at the bottom of the form.

5. The information shared may include records which may indicate the presence of a communicable or noncommunicable disease.

B. Signature - Sign and date the form in the spaces provided.

If you are agreeing to share alcohol or drug abuse records, law protects that information in certain instances. If the box under your signature is checked, the person or organization receiving your alcohol or drug abuse records under this authorization may not be able to share this information without your written permission.