GI OF NORMAN, LLC
PATIENT INFORMATION

Full Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip _____

Sex _____ Marital Status _____ SSN _____

Home Phone _____ Cell Phone (_____) _____

Employer _____ Work phone (_____) _____

Emp. Status (please circle): Full-Time Part-Time Not Employed **Student Status** (please circle): Full-Time Part-Time None

Email _____

Emergency Contact _____ Relationship _____

Phone _____

Referring Physician: _____ Primary Care Physician: _____

Pharmacy _____ Address: _____

MAKE A SELECTION FOR BOTH RACE AND ETHNICITY.

Race (please circle): Asian Native American Native Hawaiian or Pacific Islander Black or African American White Other

Ethnicity (please circle): Hispanic or Latino Not Hispanic or Latin

MINORS ONLY

Name of responsible party _____ Date of Birth _____

Relationship _____ Phone (_____) _____

Address _____

MEDICAL INSURANCE INFORMATION

1. **Primary Insurance Name & Address** _____

Policy number _____ Group number _____ Office visit co-pay _____

Policyholder _____ Policyholder Date of Birth _____

Policyholder Employer _____ Phone (_____) _____

2. **Secondary Insurance Name & Address** _____

Policy number _____ Group number _____

Policyholder _____ Policyholder Date of Birth _____

Policyholder Employer _____ Phone (_____) _____

AUTHORIZATION

I authorize release of my medical records for insurance claim purposes. This authorization also allows payment directly to physician for medical and/or procedure benefits when necessary. I also understand I am responsible for office charges at the time they incur. I am responsible for any portion of my bill not covered by my insurance company. I understand that a $25 charge may be assessed on returned checks. I hereby give permission to the providers of GI of Norman, LLC, to evaluate, administer treatment and perform minor procedures that may be deemed necessary in the diagnosis &/or treatment of my medical condition.

_____

Signature of Patient (or Parent of Minor Patient) Date

PATIENT INFORMATION

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. You may refuse to sign this acknowledgement.

Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. A copy can also be found on our website: www.giofnorman.com.

I hereby acknowledge I have received a copy of the GI of Norman, LLC, Notice of Privacy Practices.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

IF PATIENT REFUSES TO SIGN

Employee Name:_____ Date:_____

Reason:_____

_____

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

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

Name _____ Date of Birth _____

Address _____ City, State, Zip _____

Area Code & Telephone Number _____

II. SCOPE & PURPOSE FOR SHARING INFORMATION

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

III. AUTHORIZATION & 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.

A. Persons/Organizations Authorized to Receive My Information:

(Name, Address, Phone & Fax)	Relationship	Purpose (i.e "billing only" or "any")

B. Information to be shared

1. Check one or more boxes below.

- ☐ Entire Medical Record (includes all records except Psychotherapy Notes)
- ☐ Psychotherapy Notes
- ☐ Mental Health Records

☐ Pathology Report	☐ History and Physical	☐ Operation Report(s)
☐ Progress Notes	☐ Consultation Report(s)	☐ Discharge Summary
☐ EKG Report(s)	☐ Laboratory Report(s)	☐ Radiology Report(s)
☐ Physician's Orders	☐ Radiology Films	☐ Alcohol or Drug Abuse Records

- ☐ Other

2. Covering Services Between _____ and _____ (Insert either date(s) or "all.")

IV. EXPIRATION & REVOCATION

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

☐ 1 year from signature date ☐ Other (insert date if **less** than 1 year or list event): _____

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

4. I understand GI of Norman, LLC as a member of 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.

5. 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.

X _____

Printed Patient or Legal Representative Name | Capacity of Legal Representative (if applicable)

X _____

Signature (Patient or Legal Representative) | Date

Physician / Clinic Address: GI OF NORMAN, LLC, 1125 N PORTER STE 301, NORMAN, OK 73071