GastroHealth of Illinois – Patient Data

NAME____Today's Date______________________________
Social Security #_____________________________Date of Birth_____________________________
Marital status: Married Single Widowed Divorced
Gender: Male Female
Home Address____
Street City State Zip
Phone Numbers___________________________ ______________________ ______________________
Home Cell Work
Email Address____
Preferred language: English or Other____
Race: _____White_____Black/African American_____Asian_____American Indian_____Other
Ethnicity:_____Hispanic or Latino_____Non-Hispanic or Latino

Employer: ____

Insurance Information: Primary policy #______________________________Group#_______________
Name of Insured & Relationship____________________________________DOB________________

Secondary___________________policy #______________________________Group#_______________
Name of Insured & Relationship____________________________________DOB________________

Preferred Pharmacy ____

I certify that the above information is correct. I consent to be treated by the staff and providers at GastroHealth of Illinois and its affiliates. I authorize payment of medical benefits to GastroHealth of Illinois 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____

PERSONAL HISTORY/Primary Care Physician____
NAME OF CARDIOLOGIST____

MEDICAL HISTORY: Please check all that apply.
___Anemia ___Colon polyps ___GERD ___Liver Disease ___Hepatitis C
___Crohn's Disease ___Blood transfusion ___HIV/AIDS ___Pancreatitis
___Cirrhosis ___Diverticulitis ___Inflammatory Bowel Disease ___Colitis
___Irritable Bowel Disease ___Colon Cancer ___Kidney Disease ___Ulcers

SURGICAL HISTORY: Please check all that apply.
___Appendectomy ___Defibrillator ___Joint Replacement ___Tonsillectomy

___Brain surgery ___Liver surgery ___Transplant surgery ___Gallbladder surgery
___Nissen Fundoplication ___Upper endoscopy ___Gastric surgery ___Heart surgery
___Pacemaker ___Valve Replacement ___Colon surgery ___Colonoscopy ___Other

MEDICATIONS: **Please bring a complete list** or list current medications and dosage:

___________ ___________ ___________ ___________ ___________
___________ ___________ ___________ ___________ ___________

Are you currently taking blood thinners: ___Coumadin ___Warfarin ___Plavix
___Pradaxa ___Xarelto ___Other

Are you currently taking aspirin/NSAIDS:___Advil ___Aleve ___Ibuprofen ___Naprosyn

ALLERGIES: List any medication allergies-______________________________

FAMILY HISTORY (blood relative):

Colon cancer ___Yes ___No Relationship______________________________
Colon polyps ___Yes ___No Relationship______________________________
Crohn's Disease ___Yes ___No Relationship______________________________
Ulcerative Colitis ___Yes ___No Relationship______________________________

SOCIAL HISTORY – Provide details regarding current or past use of the following:

Alcohol (beer, wine, liquor) ___Yes ___No Usage______________________________
I.V. or Recreational Drugs ___Yes ___No Usage______________________________
Tobacco(cigarettes, cigars, chewing tobacco)___Yes ___No______________________________
Smoking status___every day___some days___former___never

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
I acknowledge that GastroHealth of Illinois has given me the opportunity to read a detailed notice of their Privacy Practices. I also give my written consent to allow telehealth visits between myself and Dr. Biagini. ______________________________
Signature

CONSENT TO RELEASE INFORMATION
I give permission for a representative of GastroHealth of Illinois to speak with the following individuals listed below regarding care or test results.

Name:______________________________ Phone:____________________
Relationship:______________________________

Name:______________________________ Phone:____________________
Relationship:______________________________

GASTROHEALTH OF ILLINOIS NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accounting Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
DATE OF NOTICE 04/03/2020

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your identifiable health information.
- Your privacy rights in your identifiable health information.
- Our obligation concerning the use and disclosure of your identifiable health information.

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices, Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future, Our practice will post a copy of our current notice in our office in a prominent location, and you may request a copy of our most current notice during any office visit.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Kathy, Office Manager at 309-836-3387

C. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your identifiable health information.

Treatment. Our practice may use your identifiable health information to treat you. For example, we may ask you to undergo laboratory tests and we may use the results to help us reach a diagnosis. We might use your identifiable health information in order to write a prescription for you or we might disclose your information to a pharmacy when we call and order a prescription for you. We may disclose your identifiable health information to physicians, nurses, or other healthcare personnel who may use or disclose your identifiable health information in order to treat you or assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your spouse, children, or parents.

Payment. Our practice may use and disclose your identifiable health information in order to bill and collect payment for the services you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, and pay for, your treatment. Also, we may use your identifiable health information to bill you directly for services and items.

Health Care Operations. Our practice may use and disclose your identifiable health information to operate our business. Our practice may use your health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

Appointment Reminders. Our practice may use and disclose your identifiable health information to contact you and remind you of an appointment.

Treatment Options. Our practice may use and disclose your identifiable health information to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. Our practice may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends. Our practice may release your identifiable health information to a friend or family that is helping you pay for your health care, or who assists in taking care of you.

Disclosure Required By Law. Our practice will use and disclose your identifiable health information when we are required to do so by federal, state, or local law.

Public Health Risks. Our practice may disclose your identifiable health information to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse and neglect
- Preventing or controlling disease, injury, or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices.
- Notifying individuals if a product or device they use may be using has been recalled.
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult person; however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities: Our practice may disclose your identifiable health information to a health oversight agency for activities authorized by law.

Lawsuits and Similar Proceedings. Our practice may use and disclose your identifiable health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested,

Law Enforcement. We may release identifiable health information if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe might have resulted from criminal conduct
- Regarding criminal conduct at our office
- In response to a warrant, summons, material witness, fugitive, or missing person
- In an emergency, to report a crime

Deceased Patients. Our practice may release identifiable health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

Organ and Tissue Donation. Our practice may release identifiable health information to organizations that hand organ, eye, or tissue procurement or transplantation, including organ donation banks.

Research. Our practice may use and disclose your identifiable health information for research purposes in certain limited circumstances. We will obtain your written authorization to use your identifiable health information for research purposes.

Serious Threats to Health or Safety. Our practice may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

Military. Our practice may disclose your health identifiable information if you are a member of U.S or foreign military forces (including veterans).

National Security. Our practice may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law.
Inmates. Our practice may disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
Workers' Compensation. Our practice may release your identifiable health information for workers' compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

You have the following rights regarding the identifiable health information that we maintain about you.

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner. For instance, you may ask we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to GastroHealth of Illinois specifying the requested method of contact or the location where you wish to be contacted. Our practice will accommodate reasonable requests.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment, or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment of your care. We are not required to agree with your requests; however, if we do agree, we are bound by our agreement except when otherwise required by law. In order to request a restriction in our use or disclosure of your identifiable health information, you must make your request in writing to GastroHealth of Illinois. Your request must describe in a clear and concise fashion: (a.) the information you wish restricted; (b.) whether you are requesting to limit our practice's use, disclosure or both; and (c.) to whom you want the limit to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you. You must submit your request in writing to GastroHealth of Illinois in order to inspect and/or obtain a copy of your identifiable health information. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and /or copy in certain limited circumstances; however, you may request a review of our denial.
4. **Amendment.** You may ask to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to GastroHealth of Illinois. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request in writing. Also, we may deny your request if you ask us to amend information that is (a) accurate and complete; (b.) not part of the identifiable health information kept by or for the practice; (c.) not part of the identifiable health information which you would be permitted to inspect and copy; or (d.) not created by our practice, unless the individual or entity that created the information is not available to amend to information.
5. **Accounting of Disclosures.** All of our patients have the right to request an "Accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our practice has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to GastroHealth of Illinois. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before August 16, 2014. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with the additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact GastroHealth of Illinois at (309)-836-3387.
7. **Right To File a Complaint.** If you believe your privacy rights have been violated, you file a complaint with our practice. To file a complaint with our practice, contact, Kathy, Office Manager at (309)836-3387. All complaints must be submitted in writing.

Right to Provide Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization we ill no long use or disclose your identifiable health information for the reasons described in the authorization. Please note, we are required to retain records of your care.