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.

Gastroenterology ASSOCIATES OF ATHENS

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 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 Gastroenterology Associates of Athens by _____

Address _____
Street City State Zip Phone

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 City State Zip

I authorize GAA 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 Gastroenterology Associates of Athens, a division of AGA, LLC, and other affiliates of AGA, LLC. 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 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.*

ATLANTA Gastroenterology ASSOCIATES

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS AND SAMPLE NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW

AGA, LLC d/b/a Atlanta Gastroenterology Associates ("AGA") and its affiliated companies comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. AGA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AGA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, ask to speak to the site manager.

If you believe that AGA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: AGA, LLC, ATTN: Compliance Officer, 550 Peachtree St NE, Ste 1600, Atlanta, GA 30308, (phone) 404.888.7575, (fax) 404.253.6896, or (email) hipaacompliance@atlantagastro.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1.800.368.1019, 800.537.7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

AGA offers language services free of charge to those patients requiring assistance.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

Effective Date: 10/2016

Please fill out this form and bring it to your appointment.
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gastroenterology ASSOCIATES OF ATHENS

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) Have you been to West Africa (Guinea, Liberia, Sierra Leone or other countries) in the last 21 days, where the Ebola virus transmission has been reported by the World Health Organization? ❑ Yes ❑ No

2) PATIENT MEDICAL HISTORY Check all that apply.

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

❑ Other _____

3) 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 _____

4) SURGICAL HISTORY

Check all that apply and provide dates.

- ❑ **Colon Surgery** _____
- ❑ **Colonoscopy** _____
- ❑ **Hemorrhoid Surgery** _____
- ❑ **Gallbladder Surgery** _____
- ❑ **Gastric Surgery** _____
- ❑ **Heller Myotomy** _____
- ❑ **Liver Surgery** _____
- ❑ **Nissen Fundoplication** _____
- ❑ **Small Intestine Surgery** _____
- ❑ **Upper Endoscopy (EGD)** _____
- ❑ Appendectomy _____
- ❑ Brain Surgery _____
- ❑ Breast Surgery _____
- ❑ C-Section _____
- ❑ CABG/Heart Surgery _____
- ❑ Cosmetic Surgery _____
- ❑ Defibrillator _____
- ❑ Fracture Surgery _____
- ❑ Hernia Surgery _____
- ❑ Hysterectomy
  - Abdominal _____
  - Vaginal _____
- ❑ Joint Replacement _____
- ❑ Laparotomy _____
- ❑ Obesity Surgery _____
  - Type, if known _____
- ❑ Pacemaker _____
- ❑ Prostate Surgery _____
- ❑ Spinal Surgery _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Transplant Surgery _____
- ❑ Tubal Ligation _____
- ❑ Valve Replacement Surgery _____
- ❑ Vasectomy _____
- ❑ Other _____

Name _____ Date of Birth _____

5) 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

6) ALLERGIES

List any medication allergies. ❑ No known medication allergies

_____

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

_____

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

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

8) 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 _____

9) SYSTEMS REVIEW

Do you have or have you experienced any of the following in the last 12 months?

CONSTITUTIONAL
- ❑ Body Aches
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Loss of Appetite
- ❑ Malaise (feeling ill)
- ❑ Night Sweats
- ❑ Weight Gain
- ❑ Weight Loss (dieting)
- ❑ None of the Above

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

EARS/NOSE/THROAT
- ❑ Ear Pain/Ringing
- ❑ Hearing Loss
- ❑ Mouth Ulcers/Sores
- ❑ Nose Bleeds
- ❑ Problems with Gums/Teeth
- ❑ Trouble Swallowing
- ❑ None of the Above

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

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

GASTROINTESTINAL
- ❑ Abdominal Pain/Discomfort
- ❑ Anal/Rectal Pain or Itching
- ❑ Anal Spasm
- ❑ Black Stool
- ❑ Bloating/Belching/Gaseousness
- ❑ Change of Bowel Habit
- ❑ Constipation
- ❑ Diarrhea/Loose Stool
- ❑ Difficulty in Swallowing
- ❑ Heartburn/Esophageal Reflux
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Mucus in Stool
- ❑ Nausea/Vomiting
- ❑ Rectal Bleeding (in stool, commode, toilet paper)
- ❑ Unintentional Weight Loss (not dieting)
- ❑ None of the Above

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

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

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

MUSCULOSKELETAL
- ❑ Back Pain
- ❑ Decreased Range of Motion
- ❑ Joint Pain/Arthritis
- ❑ Problems Walking/Calf or Leg Pain
- ❑ None of the Above

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

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

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

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

OTHER _____

_____

_____

_____

_____

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.

Gastroenterology ASSOCIATES OF ATHENS

FINANCIAL DISCLOSURE STATEMENT

Date _____

Patient Name _____ Date of Birth _____
(please print)

Thank you for choosing Gastroenterology Associates of Athens, a division of AGA, LLC (AGA). 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. AGA and its affiliates 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 of AGA 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 or 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.*

_____ Date _____

Witness

Please fill out this form and bring it to your appointment.
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Gastroenterology ASSOCIATES OF ATHENS

HEPATITIS C SCREENING QUESTIONNAIRE

Patient Name _____ Date of Birth _____

The hepatitis C virus (HCV) is spread through exposure to contaminated blood. This can occur by sharing drug needles, through accidental needle sticks, or from mother to child during pregnancy. In many cases, HCV has no symptoms until significant liver damage has occurred. Therefore, early detection is key to treating this virus effectively. The CDC recommends that patients who meet the below criteria complete a rapid screening test for HCV. Please answer the questions below to determine if you are a candidate for this test. Note: If you have previously been tested for HCV by any physician, your insurance carrier may not cover this test.

❑ Yes ❑ No Have you previously been tested for hepatitis C by your primary care physician or any other provider?

If yes, no need to proceed with questionnaire.
If no, please answer the following 10 questions:

1. ❑ Yes ❑ No Were you born between 1945 through 1965?
2. ❑ Yes ❑ No Are you currently or have you ever used recreational injectable and/or IV drugs?
3. ❑ Yes ❑ No Have you ever received a transfusion of plasma products (clotting factor concentrates) produced before 1987?
4. ❑ Yes ❑ No Are you currently or were you ever on long-term hemodialysis?
5. ❑ Yes ❑ No Do you have a history of persistently abnormal alanine aminotransferase levels (ALT-liver function blood test)?
6. ❑ Yes ❑ No Have you ever been diagnosed with HIV?
7. ❑ Yes ❑ No Did you receive a transfusion of blood, blood components, or an organ transplant before July 1992?
8. ❑ Yes ❑ No Are you a healthcare, emergency medical, or public safety worker who has ever had exposure to HCV-positive blood? (e.g. accidental needle stick, sharps, or mucosal exposure)
9. ❑ Yes ❑ No Are you a biological child of a HCV-positive woman?
10. ❑ Yes ❑ No Have you been exposed to HCV within the past 6 months?

Patient Signature _____ Date _____

Staff Use Only

If patient answers yes to any of the above questions and accepts screening, administer Rapid Hepatitis C test.

❑ Patient meets criteria; test administered.
❑ Patient does not meet criteria; test not administered.
❑ Patient meets criteria; patient declined screening.
❑ Patient does not meet criteria; patient desires screening.

Rapid Hepatitis C Results ❑ Positive ❑ Negative Lot # _____ Exp. Date _____

Notes _____

_____

MA Name _____ MA Signature _____

Physician Signature _____ Date _____

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.

Gastroenterology Associates of Athens, a division of AGA, LLC along with its affiliates 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

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

Health Care Operations: We 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

We 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. We 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

We may use your information to contact you with appointment reminders by phone, mail, email, or text message. We 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 us 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). We are currently participating in the Georgia Health Information Network (GaHIN) 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. In the event that 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**
  In the event that 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 AGA 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

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

- **Required by Law**
  We 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**
  We may use or disclose information for approved medical research subject to specific criteria.

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

- **Health Oversight**
  We 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**
  We may disclose information in response to an appropriate subpoena or court order.

- **Law Enforcement Purposes**
  Subject to certain restrictions, we 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**
  We 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, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

- **Workers' Compensation**
  We 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 with regard to your health information. Submit any concerns in writing to our Compliance Officer (see next page).

- **Request Restrictions**
  You may request restrictions on certain uses and disclosures of your health information. These requests must be in writing. We are not required to agree to most restrictions, but if we do agree, we must 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, we 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 we correct or amend the existing information. The request must be made in writing and include a reason to support the requested amendment. Your 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 we are 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, we 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 AGA's website. A current summary version of our Notice is available in each waiting area at all times. 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 our 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 AGA's Compliance Officer:

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

Phone: 404.888.7575
Email: HIPAAcompliance@atlantagastro.com
Website: Use Contact Form, category "HIPAA Compliance/Privacy"

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.

Gastroenterology ASSOCIATES OF ATHENS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT

I, _____ , hereby acknowledge that Gastroenterology Associates of Athens (GAA), a division of AGA, LLC and its affiliates, have given me the opportunity to read a detailed notice of their Privacy Practices.

_____ 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.*

If not signed, please provide a reason why the acknowledgement was not obtained.

_____

_____ Date _____

Witness / Staff Signature

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____ , give permission for a representative from GAA, AGA, LLC, or its affiliates to share information regarding care or tests results with the individuals listed below. These individuals may also request protected health information on my behalf.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Is it OK to leave results or information on your voicemail? ❑ Yes ❑ No

I recognize that GAA, AGA, LLC, and its affiliates 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 choose to opt out of having your information shared via health information exchange, you must request and complete an Opt-Out Form available at our office.

_____ 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.*

CONSENT TO CORRESPOND ELECTRONICALLY

While we take reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with an GAA physician regarding medical care, the GAA physician and/or his/her representative has my permission to correspond via that email address.

I give permission for an GAA physician or clinical staff member to email me at _____ @ _____ regarding medical care.

_____ 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.*