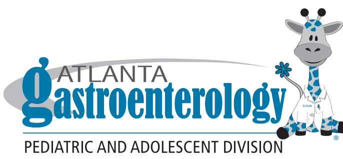


# PATIENT DATA
FORM MUST BE COMPLETED IN FULL

Today's Date ______________________

Patient's Legal Name ______________________ Goes By or Nickname ______________________

Date of Birth ______________________ Gender ❑ Male ❑ Female

Home Address ______________________
Street Apartment/Unit # City State Zip

Preferred Numbers: Primary (home or cell) ______________ Work ______________ Email ______________

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

---

PARENT / GUARDIAN INFORMATION

Mother/Guardian Name ______________________ Date of Birth ______________

Home Address (if different than above) ______________________
Street Apartment/Unit # City State Zip

Preferred Numbers: Primary (home or cell) ______________ Work ______________ Email ______________

Father/Guardian Name ______________________ Date of Birth ______________

Home Address (if different than above) ______________________
Street Apartment/Unit # City State Zip

Preferred Numbers: Primary (home or cell) ______________ Work ______________ Email ______________

Minor child lives with ❑ Both Parents ❑ Mother Only ❑ Father Only ❑ Other ______________

If parents are not married, who has primary legal custody? ❑ Mother ❑ Father ❑ Other ______________

Are there legal documents indicating who is responsible for health coverage? ❑ Yes ❑ No

If yes, who is responsible for health coverage? ______________________

---

Primary Care Physician/Pediatrician ______________________ Referring Physician ______________________

Street Suite City State Zip Phone — Street Suite City State Zip Phone

---

EMERGENCY CONTACT

Name & Relationship ______________________ Daytime Phone ______________

---

INSURANCE INFORMATION

Primary ______________ Policy # ______________ Group # ______________

Name of Insured & Relationship ______________________ DOB ______________

Secondary ______________ Policy # ______________ Group # ______________

Name of Insured & Relationship ______________________ DOB ______________

---

PREFERRED PHARMACY INFORMATION

Pharmacy Name ______________________ Pharmacy Phone ______________

Pharmacy Address ______________________
Street Suite City State Zip

I authorize AGA to communicate electronically with our preferred pharmacy to obtain the patient's prescription history. ❑ Yes ❑ No

---

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent for the patient to be treated by the staff and providers of AGA, LLC, and its affiliates. 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.

Parent / Legal Guardian Signature ______________________ Date ______________

ATLANTA Gastroenterology
PART OF UNITED DIGESTIVE

# NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS AND 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。

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક 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

ATLANTA Gastroenterology
PEDIATRIC AND ADOLESCENT DIVISION

# PERSONAL HISTORY

Today's Date ____________________

Patient's Name ____________________ Age _____ Date of Birth ____________ ❑ Male ❑ Female

Referred by ____________________ Primary Care Physician ____________________

Describe the reason(s) for the visit ____________________

____________________

How long have symptoms persisted? ____________ If a change in weight (loss/gain), list amount ____________

## 1) MEDICAL HISTORY

Please check all that apply.

❑ ADHD
❑ Allergies
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Autism
❑ Cerebral Palsy
❑ Congenital Heart Disease
❑ Crohn's Disease
❑ Depression
❑ Diabetes
❑ Eczema
❑ GERD
❑ Inflammatory Bowel Disease
❑ Irritable Bowel Syndrome
❑ Liver Disease
❑ Migraines
❑ Pancreatitis
❑ Seizures
❑ Thyroid Disease
❑ Ulcerative Colitis
❑ Ulcers

List additional medical problems or illnesses including cancers and psychiatric treatment.

____________________

____________________

## 2) VACCINES

Is patient up-to-date on vaccines? ❑ Yes ❑ No

## 3) LABORATORY TESTS

Check and provide most recent dates if patient has had any of the following labs. *Provide a copy of any lab or test results.*

❑ Blood Work ____________ ❑ Stool Study ____________ ❑ Urine ____________

## 4) HOSPITALIZATION AND SURGICAL HISTORY

Check all that apply including age and date of procedure or hospitalization.

❑ Adenoidectomy ____________
❑ Appendectomy ____________
❑ Brain Surgery ____________
❑ Colon Surgery ____________
❑ Colonoscopy ____________
❑ Fracture Surgery ____________
❑ G-Tube ____________
❑ Gallbladder Surgery ____________
❑ Heart Surgery ____________
❑ Hernia Surgery ____________
❑ Myringotomy (Ear Tubes) ____________
❑ Nissen Fundoplication ____________
❑ Small Intestine Surgery ____________
❑ Spinal Surgery ____________
❑ Tonsillectomy ____________
❑ Transplant Surgery ____________
❑ Upper Endoscopy (EGD) ____________
❑ Other ____________

## 5) IMAGING

Check and provide most recent dates if patient has had any of the following imaging services recently.

❑ Barium Swallow ____________
❑ CT Scan ____________
❑ MRI ____________
❑ Ultrasound ____________
❑ X-ray ____________
❑ Other ____________

6) MEDICATIONS

List current medications (including herbal, supplements and over-the-counter) and dosage

_______________________ _______________________

_______________________ _______________________

I authorize Atlanta Gastroenterology Associates to obtain the patient's prescription history electronically. ❑ Yes ❑ No

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

List medication, food, environmental and latex allergies including reactions to each

_______________________________________________

_______________________________________________

Does the patient have a personal history and/or is there a family history of problems with anesthesia? ❑ Yes ❑ No

7) CURRENT DIETS

For infants ❑ Breast fed ❑ Formula fed ❑ Both Current formula ____________ Formulas attempted ____________

One year and older ❑ Regular diet ❑ Special diet List details ____________________________

8) SOCIAL HISTORY

List all people that live in the same home as patient ____________________________

_______________________________________________

Is patient adopted? ❑ Yes ❑ No Is patient in foster care? ❑ Yes ❑ No

What grade is patient in? ____________ Is patient missing school? ❑ Yes ❑ No If yes, how many days per month? ____________

Is patient missing school activities? ❑ Yes ❑ No If yes, list school activities ____________________________

_______________________________________________

List any recent travel (list destination and dates) ____________________________

List the types of animals patient is around regularly ____________________________

List any family stressors (Examples: financial, marital, death, school issues) ____________________________

Alcohol (beer, wine, liquor) ❑ 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)

9) BIRTH HISTORY

Birth Weight ____________ Birth Length ____________ ❑ Full-Term ❑ Pre-Term Delivered at week # ____________

Type of Delivery ❑ Vaginal ❑ Caesarean

List any pregnancy or delivery difficulties ____________________________

_______________________________________________

10) **SYSTEMS REVIEW:** Does patient currently have or has recently experienced any of the following? Note if a family member is experiencing or has any of the following. (Family members include parents, siblings, grandparents, aunts, uncles and cousins.)

| EYES | Patient | Relative | Relation |
|---|---|---|---|
| Visual Changes | ❑ | ❑ | ________ |
| **HENT** | | | |
| Hearing Loss | ❑ | ❑ | ________ |
| Mouth Ulcers/Sores | ❑ | ❑ | ________ |
| Nose Bleeds | ❑ | ❑ | ________ |
| Poor Dentition | ❑ | ❑ | ________ |
| **CARDIOVASCULAR** | | | |
| Arrythmias (irregular heartbeat) | ❑ | ❑ | ________ |
| Chest Pain | ❑ | ❑ | ________ |
| Congenital Abnormalities | ❑ | ❑ | ________ |
| Hypertension | ❑ | ❑ | ________ |
| Mitral Valve Prolapse or Murmur | ❑ | ❑ | ________ |
| **RESPIRATORY** | | | |
| Aspiration | ❑ | ❑ | ________ |
| Asthma/Wheezing | ❑ | ❑ | ________ |
| Cough | ❑ | ❑ | ________ |
| Croup | ❑ | ❑ | ________ |
| Cystic Fibrosis | ❑ | ❑ | ________ |
| Pneumonia | ❑ | ❑ | ________ |
| RSV | ❑ | ❑ | ________ |
| Shortness of Breath | ❑ | ❑ | ________ |
| Sleep Apnea | ❑ | ❑ | ________ |
| **GASTROINTESTIONAL** | | | |
| Abdominal Pain | ❑ | ❑ | ________ |
| Anal Fissures | ❑ | ❑ | ________ |
| Anal/Rectal Pain or Itching | ❑ | ❑ | ________ |
| Black Stool | ❑ | ❑ | ________ |
| Bloating/Belching/Gaseousness | ❑ | ❑ | ________ |
| Celiac Disease | ❑ | ❑ | ________ |
| Colon Cancer | ❑ | ❑ | ________ |
| Colon Polyps | ❑ | ❑ | ________ |
| Constipation | ❑ | ❑ | ________ |
| Crohn's Disease | ❑ | ❑ | ________ |
| Diarrhea/Loose Stool | ❑ | ❑ | ________ |
| Difficulty in Swallowing | ❑ | ❑ | ________ |
| Gallstones/Gallbladder Disease | ❑ | ❑ | ________ |
| Gastrointestinal Bleeding | ❑ | ❑ | ________ |
| Hepatitis or Liver Disease | ❑ | ❑ | ________ |
| Heartburn/GERD | ❑ | ❑ | ________ |
| Intestinal Polyps | ❑ | ❑ | ________ |
| Liver Disease | ❑ | ❑ | ________ |
| Mucus in Stool | ❑ | ❑ | ________ |

| GASTROINTESTIONAL, *continued* | Patient | Relative | Relation |
|---|---|---|---|
| Nausea/Vomiting | ❑ | ❑ | ________ |
| Stomach Ulcers | ❑ | ❑ | ________ |
| Ulcerative Colitis | ❑ | ❑ | ________ |
| Unintentional Weight Loss | ❑ | ❑ | ________ |
| **GENITOURINARY** | | | |
| Female patients, date of last period ________________ | | | |
| Burning with Urination | ❑ | ❑ | ________ |
| Recent/Frequent Urinary Tract Infection | ❑ | ❑ | ________ |
| **SKIN** | | | |
| Dermatitis or Rash | ❑ | ❑ | ________ |
| Eczema | ❑ | ❑ | ________ |
| Itching | ❑ | ❑ | ________ |
| Jaundice (yellow eyes or skin) | ❑ | ❑ | ________ |
| **NEUROLOGIC** | | | |
| Autism | ❑ | ❑ | ________ |
| Developmental Delay | ❑ | ❑ | ________ |
| Headaches/Migraines | ❑ | ❑ | ________ |
| Hydrocephalus | ❑ | ❑ | ________ |
| Seizure Disorder | ❑ | ❑ | ________ |
| **MUSCULOSKELETAL** | | | |
| Joint Pain/Arthritis | ❑ | ❑ | ________ |
| Lupus, Scleroderma, Related Disease | ❑ | ❑ | ________ |
| **ENDOCRINE** | | | |
| Diabetes | ❑ | ❑ | ________ |
| Inborn Errors of Metabolism | ❑ | ❑ | ________ |
| Thyroid Problem | ❑ | ❑ | ________ |
| **PSYCHIATRIC** | | | |
| ADHD | ❑ | ❑ | ________ |
| Anxiety | ❑ | ❑ | ________ |
| Depression | ❑ | ❑ | ________ |
| **LYMPHATIC/HEMATOLOGY** | | | |
| Anemia | ❑ | ❑ | ________ |
| Bleeding Problems | ❑ | ❑ | ________ |
| Cancer | ❑ | ❑ | ________ |
| Enlarged Nodes/Swollen Glands | ❑ | ❑ | ________ |
| **ALLERGY/IMMUNOLOGY** | | | |
| Environmental Allergies | ❑ | ❑ | ________ |
| Frequent Infections | ❑ | ❑ | ________ |

**OTHER** ______________________________

Parent / Legal Guardian Signature ______________________________ Date ________________

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

Physician Signature ______________________________ Date ________________

## FINANCIAL DISCLOSURE STATEMENT

Date ____________________

Patient Name ______________________________ Patient Date of Birth ____________
(please print)

Parent / Legal Guardian Name ______________________________

Thank you for choosing AGA, LLC (AGA). Please read and sign this Financial Disclosure Statement prior to the patient's appointment. Guarantors 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 the patient's 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 benefits and obtain any necessary precertification prior to your appointment. This is not a guarantee of payment.

The insurance company will send you an Explanation of Benefits that will explain how the bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand the 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 and secondary claims on the patient's behalf as long as the information needed to process the claim is obtained and verified before the visit. If this information is obtained after the visit or if the information provided is deemed inactive for the dates of service, the 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. For all outstanding balances, AGA will send statements to the responsible party's address. If there is 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 the 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 visit**, call the office and ask to speak to the financial counselor.
- **For previous visits,** call 678.223.7788.

If the patient is unable to keep the 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.

**Divorced Parents**: In cases of divorce or separation, the parent authorizing treatment/services for the minor patient will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the charges, it is the authorizing parent's responsibility to collect from the other parent. Neither AGA nor its affiliates will mediate payment between parents.

### 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 services 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, 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 the patient's health plan.

______________________________ Date ____________
Parent / Legal Guardian Signature

______________________________ Date ____________
Witness

ATLANTA Gastroenterology
PART OF UNITED DIGESTIVE

# 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.

AGA, LLC and its affiliates ("AGA") 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**

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

**Health Care Operations:** AGA 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**

AGA 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. AGA 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**

AGA may use your information to contact you with appointment reminders by phone, mail, email, or text message. AGA 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 AGA 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 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**

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

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

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

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

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

- **Workers' Compensation**
  AGA 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 AGA'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. AGA 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, AGA 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 AGA correct or amend the existing information. The request must be made in writing and include a reason to support the requested amendment. Your AGA 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 AGA 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, AGA 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 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 AGA'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 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: compliance@atlantagastro.com
Website: Use Contact Form, category "HIPAA Compliance/Privacy"

ATLANTA Gastroenterology PART OF UNITED DIGESTIVE

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name ______________________________ Date of Birth ______________

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, hereby acknowledge that AGA, LLC and its affiliates (AGA) have given me the opportunity to read a detailed notice of their Privacy Practices.

## CONSENT TO COMMUNICATE WITH YOU

❏ I authorize AGA to leave results or protected health information on my voicemail. ❏ Home ❏ Cell ❏ Work

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

❏ I authorize my AGA 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 AGA to communicate with anyone other than me, excluding all disclosures allowed by law.

❏ I authorize representatives from AGA 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 AGA 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 AGA 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

# AUTHORIZATION FOR OTHERS TO ACCOMPANY AND CONSENT TO TREAT MINOR PATIENT

**Complete this form ONLY if the patient is authorized to attend future visits alone or with someone other than their parent/legal guardian.**

Patient Name ______________________________ Date of Birth ____________________

For the first office visit, we require that a parent or legal guardian accompany the patient. For future appointments, other individuals may bring the patient, as long as the parent has given written consent, and that consent is on file in our office. The authorized individuals are required to bring photo identification. In limited circumstances, the patient may come unaccompanied by an adult. If any of these situations apply, complete the applicable sections below. **This form must be notarized. For your convenience, a Notary Public is typically present in the Pediatric and Adolescent Office.**

## AUTHORIZATION TO ACCOMPANY AND/OR CONSENT TO TREATMENT PATIENT

I hereby authorize the following individuals to bring the patient to AGA, LLC, for treatment and to exchange necessary information (including test results, care plan, etc.) with medical personnel. By checking the box next to the individual's name, I also grant this individual the right to give consent to medical treatment. This request will remain in effect for one year or until revoked by me in writing.

| | Name | Relationship to Patient | Authorization to Consent to Medical Treatment |
|---|---|---|---|
| 1) | | | ❑ |
| 2) | | | ❑ |
| 3) | | | ❑ |
| 4) | | | ❑ |

## LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none".

______________________________________________

______________________________________________

If medical care is of an urgent nature, please contact one of the parents/legal guardians listed below regarding the healthcare of the of minor patient listed above.

Parent/Legal Guardian ____________________ Primary Phone ____________ Secondary Phone ____________

Parent/Legal Guardian ____________________ Primary Phone ____________ Secondary Phone ____________

❑ If you are unable to contact either parents/legal guardian, you may rely on the authorized individual who brought the child to the medical appointment.

## PREAUTHORIZATION TO TREAT UNACCOMPANIED MINOR

❑ I authorize the patient, listed above, to independently attend appointments and receive any treatment for which I previously provided consent.

**I understand that I am financially responsible for all medical expenses incurred by the patient incurred during these appointments.**

Parent/Legal Guardian Name ______________________________

Parent/Legal Guardian Signature ______________________________ Date ____________________

In witness whereof, the undersigned has executed this instrument as of the _____ day of _____________ , 20___ .

Subscribed to and sworn before me this _____ day of _____________ , 20___ .

Notary Public ______________________________

My commission expires ______________________________

[SEAL]