WESTSIDE GASTROENTEROLOGY ASSOCIATES

PLEASE FILL OUT COMPLETELY DATE _____

FIRST NAME | MIDDLE | LAST NAME | FORMER LAST NAME (IF CHANGED)

ADDRESS | STREET | APT # | CITY | STATE | COUNTY | ZIP

SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE

MARITAL STATUS	RACE	SEX
☐ MARRIED ☐ LEGALLY SEPARATED	☐ WHITE ☐ NATIVE HAWAIIAN	☐ MALE
☐ SINGLE	☐ BLACK ☐ MIXED	☐ FEMALE
☐ DIVORCED	☐ HISPANIC ☐ OTHER	
☐ WIDOWED	☐ NATIVE AMERICAN ☐UNKNOWN	

HOME PHONE | CELL PHONE | E-MAIL ADDRESS (OPTIONAL)

EMPLOYER | OCCUPATION | WORK PHONE

EMPLOYERS ADDRESS | CITY | STATE | ZIP

SPOUSE'S NAME | SPOUSE'S EMPLOYER

EMERGENCY CONTACT – NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU | RELATIONSHIP | PHONE

REFERRED BY:_____PHONE_____FAX_____

PRIMARY CARE PROVIDER:_____PHONE_____FAX_____

INSURANCE: (PRIMARY)_____ (SECONDARY)_____

PLEASE COMPLETE SECTION BELOW IF YOU ARE *NOT* THE POLICY HOLDER

RESPONSIBLE PARTY

NAME | DOB | ADDRESS | CITY | STATE | ZIP

HOME PHONE | BUSINESS PHONE | RELATIONSHIP | SOCIAL SECURITY

Health History Form

WESTSIDE Gastroenterology ASSOCIATES

Date: _____

Patient Name: _____ Date of Birth _____ Age _____
Referred by: _____ Phone # _____
Primary Care Physician: _____ Phone # _____

1. **Describe your current problem(s):**

A. _____

B. _____

2. **History of Present Illness** (your current symptoms). Check all that apply.

- ☐ Heartburn
- ☐ Trouble swallowing
- ☐ Painful swallowing
- ☐ Nausea/Vomiting
- ☐ Pain/Burning in stomach
- ☐ History of ulcers
- ☐ Vomiting blood
- ☐ Bloody stools
- ☐ Anemia (low blood count)
- ☐ Hepatitis/type _____
- ☐ Jaundice
- ☐ Liver problems
- ☐ Pancreas problems
- ☐ Gallbladder problems
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Bloating
- ☐ Flatulence
- ☐ Weight loss
- ☐ Fever
- ☐ Lack of appetite
- ☐ Family history of polyps
- ☐ Family history of colon cancer
- ☐ Family history of ulcers
- ☐ Family history of colitis
- ☐ Family history of gallstones

3**. Past History**

A. **Surgical**-Check all that apply. List year and any comments.

- ☐ Appendectomy _____
- ☐ Breast surgery _____
- ☐ Colon surgery _____
- ☐ Gallbladder surgery _____
- ☐ Heart _____
- ☐ Brain _____
- ☐ Hemorrhoidectomy_____
- ☐ Hernia repair _____
- ☐ Hysterectomy _____
- ☐ Ovaries removed _____
- ☐ Joint replacement _____
- ☐ Spine _____
- ☐ Stomach surgery _____
- ☐ Thyroid surgery _____
- ☐ Tonsillectomy _____

Other _____

B. **Medical History**-Check all that apply. List the year and any comments:

- ☐ Hepatitis _____
- ☐ Other liver disease _____
- ☐ Lung disease _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Stomach/intestine _____
- ☐ Seizures _____
- ☐ Cancer _____
- ☐ Arthritis _____
- ☐ Psychiatric _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Enlarged prostate _____
- ☐ Thyroid disorder _____
- ☐ High cholesterol _____
- ☐ Other _____

C. Allergies: ☐ Pcn ☐ Sulfa ☐ Codeine ☐ Latex ☐ Other _____

D. **Medications:**

Name	Strength	How often	Name	Strength	How often

E. **Do you take**:

- ☐ aspirin or arthritis medications_____
- ☐ Blood thinners-Coumadin, Plavix_____
- ☐ Herbal supplements_____

F. **Latex Allergy Screening:**

- ☐ Do you have a latex allergy?
- ☐ Do any of the following apply to you:
  - ☐ Spina Bifida?
  - ☐ Self Catheterization?
  - ☐ Urinary problems at birth?
  - ☐ Allergy to bananas, avocadoes, tropical fruits or chestnuts?
  - ☐ Have you ever had itching, rash, wheezing or watery eyes after using household rubber gloves?

If you answered YES to any of the above:

- ☐ Were you tested for latex allergy?
- ☐ Was an allergy identified?
- ☐ Specify type of allergy: _____

4. **Family History:** **F**=father **M**=mother **D**=daughter **A**=aunt
B=brother **S**=sister **S**=son **U**=uncle **G**=grandparent

Colon cancer _____
Stomach cancer _____
Colitis _____
Colon polyps _____
Crohn's _____
Diabetes _____
Gallstones _____
Heart disease _____
High blood pressure _____
Liver disease _____
Mental disease _____
Pancreatitis _____
Stroke _____
Tuberculosis _____
Ulcerative colitis _____
Stomach ulcers _____
Other _____

5**. Social History** (If yes, please indicate how much per day)

☐Smoke _____(pk/day)
☐Drink alcohol _____(oz/day)
☐Drink coffee _____(cups/day)
☐Drink tea _____(glasses/day)
☐Drink milk _____(glasses/day)
☐Drink carbonated beverages _____

6. **Review of Systems**. Check all that apply

HEENT
☐History of Nosebleeds
☐Sinus/postnasal drip
☐Ringing in ears
☐Sore Throat
☐Other _____

PULMONARY
☐Chronic cough
☐Cough up blood
☐Asthma/wheezing
☐Short of breath
☐Last flu shot_____
Last pneumonia vaccine_____

CARDIAC
☐Chest pain
☐Palpitations
☐Swollen ankles
☐Short of breath lying down
☐Last EKG _____

GI
☐Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Difficulty swallowing
☐Other _____

GU
☐Painful urination
☐Blood in urine
☐Urethral discharge
☐Urinate frequently
☐Difficulty starting stream
☐Other _____

GYN
☐Vaginal bleeding
☐Vaginal discharge
☐Lower abdominal pain
☐Irreg vaginal bleeding
☐Last mammogram _____
Last GYN exam _____

NEURO
☐Dizziness
☐Vertigo
☐TIA
☐Memory problems
☐Other _____

OPHTHALMOLOGIC
☐Red eye
☐Blurred vision
☐Painful eye
☐Blind spots
☐Other _____

ENDOCRINE
☐Hot/Cold
☐Excessive thirst
☐Excessive urination
☐Significant weight gain/loss
☐Other _____

HEMATOLOGIC
☐Tired
☐Irregular bleeding
☐Easy bruising
☐Blood clots
☐Other _____

PSYCHOLOGICAL
☐Inability to sleep
☐Panic attacks
☐Anxiety all the time
☐Inability to think
☐Other _____

DERMATOLOGIC
☐Skin rash
☐Hair loss
☐Change in skin color
☐Change in mole
☐Itching
☐Other _____

DENTAL
☐Gum bleed
☐Tooth pain
☐Bad breath
☐Sensitive teeth
☐Loss of teeth
☐Dentures/partials
☐Other _____

MUSCULOSKELETAL
☐Joint swelling
☐Joint pain
☐Pain not relieved by rest
☐Spine pain
☐Other

Height _____ Weight _____

7. **Additional information**:

_____
_____
_____

I have filled this form out to the best of my abilities as accurately as possible.

_____
Patient Signature Date

Reviewed by Initials
☐Jasmine Jeffers, MD _____

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Disclosures We Have Made. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

Right to Request an Alternative Method of Contact. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an Alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

Right to Notification if a Breach of Your Medical Information Occurs. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- ❑ A brief description of what happened;
- ❑ A description of the health information that was involved;
- ❑ Recommended steps you can take to protect yourself from harm;
- ❑ What steps we are taking in response to the breach; and,
- ❑ Contact procedures so you can obtain further information.

Right to Opt-Out of Fundraising Communications. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

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.

Effective Date: May, 28, 2014

Privacy Officer:
Devon Spencer

Westside Gastroenterology Associate
3825 Medical Park Drive, Suite 300
Austell, Georgia, 30106
770-941-4810
A personal approach to patient care.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Persons Involved in Your Care. We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: if the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person repsonsible for the minor except in limited circumstances.

Required by Law. We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

National Priority Uses and Disclosures Made Without Your Consent or Authorization. When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

- Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
- Threat to health or safety, such as to avert or lessen a serious threat;
- Workers' compensation or similar programs, such as for the processing of claims;
- Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim of abuse;
- Health oversight activities, such as to a government agency to investigate possible insurance fraud;
- Court or legal proceedings, such as if a judge orders us to do so;
- Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
- Coroner or medical examiner for identification of a body;
- Public health activities, such as required by the US Food and Drug Administration (FDA); and
- Certain government functions, such as using or disclosing for government functions like military and veterans' activities and national security and intelligence activities.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission) from you or your personal representative:

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will breifly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775
Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Email: OCRComplaint@hhs.gov

Right to Request Restrictions on Uses and Disclosures. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restrictions(s).

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Westside Gastroenterology Associates

Patient Acknowledgement Form for

Patient Name: _____
(Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The Practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the Westside Gastroenterology Associates to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: yes_____ no_____ Cell phone: yes____ no_____
Voice Mail/Answering machine: yes_____ no_____ Work phone: yes_____ no_____
Pager: yes____ no_____
May we fax medical records for referrals? yes_____ no_____
Please list names of people with whom we can discuss your medical care:
Spouse Name_____
Parent Name_____
Other Name (s) & Relationship _____
_____
Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier:_____
(last four digits of your social security number or mother's maiden last name)

I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Signature of Patient or Personal Representative:

_____ **Date:**_____

If Personal Representative, give relationship to patient:

_____

Westside Gastroenterology Associates
Jasmine Jeffers, MD

Austell Office
3825 Medical Park Drive SW
Suite 300
Austell, Georgia 30106 - 1109

Phone: 770-941-4810
Fax: 770-948-9149

Acknowledgement of Receipt of "NOTICE OF PRIVACY PRACTICES" for Protected Health Information

I, acknowledge that I have received a copy of WESTSIDE GASTROENTEROLOGY ASSOCIATES "Notice of Privacy Practices" for Protected Health Information on the date set forth below.

Patient Name	Date of Receipt
_____	_____
Print Name of Authorized Personal Representative	Signature of Authorized Personal Representative

Please Indicate Relationship to Patient

FOR USE BY WESTSIDE GASTROENTEROLOGY ASSOC. PERSONNEL ONLY: (Complete if Patient Acknowledgement is not obtained)

An Acknowledgement of Receipt of Notice of Privacy Practices was not obtained because:

[ ] Patient refused to sign Acknowledgement.

[ ] Unable to gain signed Acknowledgement due to communication/language or other barrier.

[ ] Patient was unable to sign Acknowledgement due to emergency treatment situation.

[ ] Other: Please indicate reason_____

Signature of WESTSIDE GASTROENTEROLOGY ASSOCIATES Representative:_____

CONSENT AND RELEASE

1. The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

2. Patient or legal custodian authorized the Staff Physician (s) or Nurse Practitioner to examine and treat the above patient.

3. Westside Gastroenterology is granted permission to release to the insurance carriers, referring physician and primary care physician any information deemed necessary, as may be requested, relating to any treatment rendered to patient.

4. Patient or legal custodian shall agree to pay to Westside Gastroenterology such sums as are, or may become, due for services rendered to the patient.

5. ALL COPAYS AND DEDUCTIBLE ARE DUE AT THE TIME OF SERVICE INCLUDING ANY OUTSTANDING BALANCES.

6. In the event that the patient's insurance company does not make full payment on this obligation, all balances will be due and immediately payable by the patient and/or legal custodian.

7. A returned check fee of $30 will be assessed on any and all returned checks.

8. Delinquent accounts will be assessed all collection, legal, and administrative costs to the fullest extent of the law.

9. Patient or legal custodian understands that if their insurance company requires that a referral be issued, it must be received at time of service. If seen without a valid referral the patient accepts responsibility for full payment at the time of service with understanding that no claim will be filed with the insurance carrier.

Our fees for surgical procedures will vary depending on the service provided. We will ask for the patient's portion of the surgical bill at the time of the surgery (outstanding deductible and /or copay). You will receive separate bills from the surgery facility, lab, etc.

INSURANCE PAYMENT PLAN

We will file insurance with your provider according to your individual plan. The patient will be responsible for any outstanding deductible, their % and / or co-pay. Referral numbers required by some insurance companies must be given at the time of service, otherwise the service becomes the patient's responsibility. For all private insurance companies, the patient will be responsible for payment at time of service. We will provide the necessary information for the patient to file for reimbursement.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, otherwise payable to me for services as described, realizing that I am responsible to pay non-covered services.
SIGNATURE_____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.
SIGNATURE_____ DATE _____

PLEASE INITIAL EACH LINE ACKNOWLEDGING THAT YOU HAVE READ AND WILL COMPLY WITH OUR OFFICE POLICIES.

_____ All fees including copays, coinsurance, deductibles, and balances are due at the time of service.

_____ It is the patient's responsibility to notify the office of any changes to your insurance, address, or contact information .

_____ If refills are needed, an appointment is required. Please do not wait until you are out of medication

_____ Test results including: labs, pathology, radiology, stool studies etc. require at least **3-4 business days** to be obtained and released by the provider.

_____ Messages left for the provider and /or nurses will be addressed and returned within 48 hours. If you have left a previous message, please wait the allowed time before you call again.

_____ _____

Patient Signature **Date**

Westside Gastroenterology Associates
Patient Portal Informed Consent

Patient Information

Name: _____
First MI Last

DOB:_____ Email address: _____

Purpose of this Form

Westside Gastroenterology Associates offers secure viewing of parts of your medical record and communication from our staff as a service to our patients. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. This service is optional and not necessary to interact and communicate with our clinic.

How the secure patient portal works

A secure Web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site.

How to participate in our patient portal

You can pick up secure messages or view information sent to you through a website. Once this form is agreed to and signed, we will send you an e-mail notification that tells you how to register for the first time. This notification will give you the URL (internet address) of the website where you can log in using the username and password provided. Next you will be able to look in your message box and see any new or old messages or view other parts of your electronic medical record. You can read or view information on your computer, but it is still encrypted in transmission between the website and your computer. You can access the Patient Portal through our clinic web page: www.westsidegastro.com

Protecting your private health information and risks

This encrypted method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. When you pick up secure messages from the portal, you need to keep unauthorized individuals from learning your password and gaining access to your account. If you think someone has learned your password, you should promptly go to the website and change it. You need to make sure we have your correct e-mail address and are informed if it ever changes. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible and will never sell or give away any private information, including e-mail addresses.

Conditions of participating in the patient portal

Access to the secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate the service we will notify you as promptly as we reasonably can. You agree to not hold Westside Gastroenterology Associates or any of its staff liable for network infractions beyond their control.

Patient Acknowledgement:_____

Date:_____

WESTSIDE Gastroenterology ASSOCIATES

DR. JASMINE JEFFERS MD
3825 MEDICAL PARK DRIVE SUITE 300 AUSTELL, GEORGIA 30106
PH: 770-941-4810 FAX: 770-948-9149

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Previous Name: _____ **Social Security #:** _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **WESTSIDE GASTROENTEROLOGY ASSOCIATES**

Address: **3825 MEDICAL PARK DRIVE SUITE 300**

City: **AUSTELL** State: **GEORGIA** Zip Code: **30106**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

HIPPA does not require consent or authorization for disclosure of protected health information for the purpose of treatment by any health care provider. HIPPA allows providers to use or disclose PHI in consulting with other providers about the individual's treatment, without the patient's specific permission. Under HIPPA, a provider may share PHI without the patient's authorization for its own payment purposes including to insurers, third party administrators, self-funded insurance plans, collection agencies, and credit reporting agencies. In addition, a provider may disclose PHI to another provider so that the other provider may be paid (for example, to a laboratory that needs insurance information so that it can be paid for the services it provided to the patient under the physician's orders.) However, under **Georgia** law, a provider is required to obtain a patient's consent to release medical records to others, including other physicians. If you receive a request to transfer medical records, you will need the patient's specific consent to do so.

Patient Signature: _____ Date Signed: _____