

WESTSIDE GASTROENTEROLOGY ASSOCIATES

PLEASE FILL OUT COMPLETELY

DATE _____

FIRST NAME	MIDDLE	LAST NAME	FORMER LAST NAME (IF CHANGED)		
ADDRESS	STREET	APT #	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER			DATE OF BIRTH	AGE	

MARITAL STATUS	RACE	SEX
<input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED	<input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN	<input type="checkbox"/> MALE
<input type="checkbox"/> SINGLE	<input type="checkbox"/> BLACK <input type="checkbox"/> MIXED	<input type="checkbox"/> FEMALE
<input type="checkbox"/> DIVORCED	<input type="checkbox"/> HISPANIC <input type="checkbox"/> OTHER	
<input type="checkbox"/> WIDOWED	<input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> UNKNOWN	

HOME PHONE	CELL PHONE	E-MAIL ADDRESS (OPTIONAL)
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EMPLOYER	OCCUPATION	WORK PHONE
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EMPLOYERS ADDRESS	CITY	STATE	ZIP
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SPOUSE'S NAME	SPOUSE'S EMPLOYER
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EMERGENCY CONTACT – NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	PHONE
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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
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HOME PHONE	BUSINESS PHONE	RELATIONSHIP	SOCIAL SECURITY
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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.

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

3. Past History

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Hemorrhoidectomy _____ | <input type="checkbox"/> Stomach surgery _____ |
| <input type="checkbox"/> Breast surgery _____ | <input type="checkbox"/> Hernia repair _____ | <input type="checkbox"/> Thyroid surgery _____ |
| <input type="checkbox"/> Colon surgery _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Gallbladder surgery _____ | <input type="checkbox"/> Ovaries removed _____ | Other _____ |
| <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Joint replacement _____ | |
| <input type="checkbox"/> Brain _____ | <input type="checkbox"/> Spine _____ | |

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Enlarged prostate _____ |
| <input type="checkbox"/> Other liver disease _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Thyroid disorder _____ |
| <input type="checkbox"/> Lung disease _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> High cholesterol _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Psychiatric _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Diabetes _____ | |
| <input type="checkbox"/> Stomach/intestine _____ | <input type="checkbox"/> Glaucoma _____ | |

C. Allergies: Pcn Sulfa Codeine Latex Other _____

D. Medications:

Name	Strength	How often	Name	Strength	How often

E. Do you take:

- | | |
|---|--|
| <input type="checkbox"/> aspirin or arthritis medications _____ | <input type="checkbox"/> Self Catheterization? |
| <input type="checkbox"/> Blood thinners-Coumadin, Plavix _____ | <input type="checkbox"/> Urinary problems at birth? |
| <input type="checkbox"/> Herbal supplements _____ | <input type="checkbox"/> Allergy to bananas, avocados, tropical fruits or chestnuts? |
| | <input type="checkbox"/> Have you ever had itching, rash, wheezing or watery eyes after using household rubber gloves? |

F. Latex Allergy Screening:

- Do you have a latex allergy?
- Do any of the following apply to you:
- Spina Bifida?
- 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

B=brother

M=mother

S=sister

D=daughter

S=son

A=aunt

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 _____

Difficulty starting stream
 Other _____

Irregular bleeding
 Easy bruising
 Blood clots
 Other _____

PULMONARY

Chronic cough
 Cough up blood
 Asthma/wheezing
 Short of breath
 Last flu shot _____
Last pneumonia vaccine _____

GYN

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

PSYCHOLOGICAL

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

CARDIAC

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

NEURO

Dizziness
 Vertigo
 TIA
 Memory problems
 Other _____

DERMATOLOGIC

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

GI

Nausea
 Vomiting
 Diarrhea
 Constipation
 Difficulty swallowing
 Other _____

OPHTHALMOLOGIC

Red eye
 Blurred vision
 Painful eye
 Blind spots
 Other _____

DENTAL

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

GU

Painful urination
 Blood in urine
 Urethral discharge
 Urinate frequently

ENDOCRINE

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

MUSCULOSKELETAL

Joint swelling
 Joint pain
 Pain not relieved by rest
 Spine pain
 Other _____

HEMATOLOGIC

Tired

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 mail 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 responsible 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 briefly 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.

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

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

_____ 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.

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

Patient Signature

Date



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: _____