JAY A. CHERNER, M.D.

A Division of

GASTROENTEROLOGY CONSULTANTS, P.C.

General Information

Today's date:_____ Nickname_____

Please print name as it appears on your insurance card

Patient Name (LAST):_____ (FIRST)_____ (Middle initial)___

Address: _____ City: _____

State: _____ Zip: _____ Patient's Social Security # (SSN): _____ / _____ / _____

Telephone Numbers: Home: _____Cell:_____ Work:_____

Fax number (optional): _____E-mail address (optional)_____

Date of Birth: _____ *Circle one*: MALE FEMALE Driver's License Number_____

Marital Status: ___Married ___Single ___Widowed ____Divorced ___Partnered

Spouse Name: _____ Spouse Date of Birth_____

Spouse Cell Phone:_____

Emergency contact *(not* living with you): _____
Relationship:_____ Cell Phone:_____

Patient Employer: _____ Employer Address:_____
City:_____ Zip:_____

Primary Insurance Co. (*Please list both name and address*):

_____

ID#:_____ Group #:_____

Policy Holder Name: _____ Policy Holder Birth Date:_____
_____

Secondary Insurance Co. (*Please list both name and address*):

_____

ID#:_____ Group #:_____

Policy Holder Name:_____ Policy Holder Birth Date: _____

REFERRED BY:_____

PRIMARY CARE PHYSICIAN:_____

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General Information

Patient's Name:_____

INSURANCE AUTHORIZATION/ASSIGNMENT:
I hereby authorize **Gastroenterology Consultants, P.C.** to release necessary information to insurance carriers acquired in the course of my treatment.

Signature:_____ *Date*:_____

I hereby assign payment of medical benefits for me or my dependent(s) to **Gastroenterology Consultants, P.C.**

Signature:_____ *Date*:_____

I hereby authorize payment of medical benefits billed to my insurance to _____. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

I will pay by (check one): □ cash □ check □ credit card

_____ _____

Signature of patient or guardian *Date*

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ , hereby authorize **Gastroenterology Consultants, P.C.** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the physicians of **Gastroenterology Consultants, P.C.** can refuse to treat me.

I have been informed that **Gastroenterology Consultants, P.C.** has prepared a notice ("Notice"), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Gastroenterology Consultants, P.C.** in writing, but if I revoke my consent, such revocation will not affect any actions that **Gastroenterology Consultants, P.C.** took before receiving my revocation.

I understand that **Gastroenterology Consultants, P.C.** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that **Gastroenterology Consultants, P.C.** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Gastroenterology Consultants, P.C.** does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice of **Gastroenterology Consultants, P.C.** must adhere to such restrictions.

I authorize **Gastroenterology Consultants, P.C.** and/or the **Georgia Endoscopy Center, L.L.C.** to leave a message regarding my appointments, treatment and results via (*please initial each response authorized*):

_____ home phone _____work phone _____ e-mail _____ cell phone

_____ _____ Date:_____

Signature of patient or patient's representative

(Form must be completed before signing)

_____ _____

Printed name of patient or patient's representative

_____

Relationship to the patient

Please list below the names of anyone to whom we may speak and/or to whom we may release information on your behalf.

_____

_____

_____

Jay A. Cherner, M.D.

A division of

Gastroenterology Consultants P.C.

www.drjaycherner.com

NOTICE OF PRIVACY PRACTICES

This notice applies to **Gastroenterology Consultants P.C. ("GC")** and all of its subsidiaries. This Notice describes how medical information about you may be used and disclosed and you can get access to this information. **Please review it carefully.** You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information 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 Patient Health Information

We use health information about you for treatment, to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are or may be participating in your treatment, to pharmacists or pharmacy personnel who are filling your prescriptions and to family members, significant other, health aid (s) or surrogates who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders via phone, fax, email, postcard or letter. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

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

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries or events.

Research: We may use or disclose information for approved medical research.

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

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate

subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding death to coroners, medical examiners, funeral directors and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in your records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our Contact Person. You may mail in your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Amend Information: If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the Office Manager at this location.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the Office Manager at the location of your GC physician. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Effective Date: December 1, 2006

I_____, hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed_____

Date_____

Relation to patient_____

Jay A. Cherner M.D.

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www.drjaycherner.com

Authorization to Release Medical Records

Patient Name:

Previous Name
(if applicable)

Date of Birth SSN#

PRACTICE or INSTITUTION RELEASING INFORMATION
Name:_____
Address:_____
_____
Phone:_____
Fax:_____

SEND RECORDS TO:
Jay A. Cherner, M.D.
Gastroenterology Consultants, P.C.
3330 Preston Ridge Rd., Suite 220
Alpharetta, GA 30005
Fax: 770-410-0006 Phone: 770-410-1600

Specific Description of Information – indicate treatment dates for each requested item

☐ Office Notes	From ____	To _____	☐ Radiology Reports	From _____	To _____
☐ Lab Reports	From ____	To _____	☐ Pathology Reports	From _____	To _____
☐ Procedure Reports	From ____	To _____	☐ Entire Record – all documents listed above without exception		

The information described above will be used or disclosed for the following purpose(s):

☐Continuity of care	☐Moving	☐Transfer of care	☐Disability determination
☐Insurance	☐Patient's copy	☐Attorney request	☐Other_____

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary. I understand that the ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a records-related treatment. I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations then such information may be re-disclosed and will no longer be protected. I understand that I have a right to revoke this authorization by sending written notification to: Gastroenterology Consultants P.C., 3330 Preston Ridge Rd., Suite 220, Alpharetta, Georgia 30005. Any revocation will not affect disclosures made prior to Gastroenterology Consultants P.C. receipt of knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form. I certify that I have received a copy of this authorization.

Signature of patient or patient's rep	Printed name of patient's representative	Relationship to patient

Date: _____

Expiration date of authorization: _____ (unless otherwise noted, this authorization will expire 12 months from the date of signature)