Gulf Coast Gastroenterology
104 Circle Way, Suite B • Lake Jackson, Texas 77566
(979) 297-4033 Fax (979) 297-0099

Name: ____
(First) (Middle) (Last)

Patient's DOB ________________ SS# _____________ ☐ Male ☐ Female Race____________

Home Phone________________ Work Phone________________ Cell Phone_________________

Address_______________________________ City______________ State_____ Zip_________

Email Address ____

Employer ____________________________________Position _________________________

Marital Status ☐**S** ☐**M** ☐**D** ☐**W** ☐**Sep** ☐**DP** Spouse/ Partner Name___________________

Emergency Contact ____________________ Phone # _____________ Relationship____________

Primary Physician ________________________ Referring Physician _______________________

Pharmacy ______________________________ Phone # ______________________________

Patient Responsibility Agreement

It is your responsibility to be informed about your health benefits. The employer that your coverage is through (or agent, for individual policies) should provide you with detailed information about what your benefits are and how your benefit program works. You should have a customer service phone number on the back of your I.D. card that you can call for assistance.

You **MUST** present your I.D. card when you arrive at our office for medical care. Failure to do so could result in additional out of pocket cost to you at the time of service. Co-pays are due and payable at the time of service. The co-pay amount for your benefit plan should be on your I.D. card. If not, you should know what your co-pay amount is for your particular plan. Our office reserves the option of rescheduling any non-emergency appointments when patients are not prepared to pay their co-pays.
If our office is unable to verify eligibility or benefits prior to services being rendered, we may ask you to pay the charges in full and we will reimburse you after the verification is obtained.

Referral Numbers
Some managed care plans require referral numbers if you must see a physician other than your primary care physician. Please call your primary care physician before your scheduled appointment so that your primary care physician can obtain a referral number for you. Your primary care physician cannot obtain a referral number after you see the specialist. We MUST have the referral number before the doctor can see you.

Notice of Privacy Practices
There is a copy of this office's Notice of Privacy Practices provided in each exam room, for your convenience, which explains how medical information will be used and disclosed. A copy of this policy is available upon request.

I hereby authorize my physician to apply for benefits on my behalf for covered services rendered by him.
I request that payment form my insurance company be made directly to my physician. I hereby authorize treatment by GULF COAST GASTROENTEROLOGY/William Sweatt, M.D.

____ ____________________
(Signature) (Date)

Name___________________________________ DOB__________________ Today's Date____________

What is the reason you came to see Dr. Sweatt today?
____
____

List any blood work or X-rays that you have had in the past 6 months and where we can obtain copies:
____
____

Please list ALL ALLERGIES including any medications and the reactions/side affects that you have had to each: **NONE**
____
____
____
____

Do you have any allergies to LATEX or rubber products? (As used in gloves?) Yes_______ No_______

Please List ALL MEDICATIONS WITH MILLIGRAMS, QUANTITIES, AND HOW OFTEN they are taken. List any OVER-THE- COUNTER MEDICATIONS that you are taking to include vitamins, arthritis medications, and aspirin products.
____
____
____
____
____

Have you ever had any of the following GI Procedures?

COLONOSCOPY (scope that looks in the large colon) Yes______ No______
If yes, then list date of last procedure, who preformed the procedure______________________________
____
Findings? ____

EGD (scope that looks in throat and large stomach) Yes _____ No ______
If yes, list date of last procedure, who preformed the procedure _________________________________
Findings? ____

Flexible Sigmoidoscopy (scope that looks in the rectum and bottom third of colon) Yes ______ No_____

X-Ray tests? Upper GI ____ Barium Enema _____ Small Bowel Series _____ Cat Scan _____ MRI___

Do you use tobacco products? Yes ____ No_____ How much each day? _____Quit? ____ When? ____

Do you consume any alcohol? Yes ____ No _____ How much each day? _____ Quit? ____ When _____

Have you ever had any previous problems with sedation or anesthesia? Yes____ No____

If yes, please explain____

Do you have a LIVING WILL or advanced directive? Yes_____ No _______

Are you and organ donor? Yes _____ No _____

Name: _______________________________ DOB: _________________ Today's Date______________

Family History

Is your mother alive? Yes____ No____ If no, Please list the cause of death ________________________
Is your father alive? Yes ____ No ____ If no, Please list the cause of death ________________________

Number of Siblings: Brothers _____ Sisters______ Have any of your brothers or sisters been diagnosed with any serious illnesses; including any cancers? ____

Please check if you have had any of these **SURGERIES:**

_____ Heart Surgery
_____ Prostate Surgery
_____ C-Section
____ Hysterectomy
____ Colon Surgery
____ Tubal Ligation
____ Ovaries Removed
____ Gall Bladder
____ Hernia Repair
____ Appendix
____ Back Surgery
____ Tonsillectomy

____Last Menstrual Period
____ Total # of Pregnancies
____ Total # of Births
____ # of Children

List any orthopedic surgeries____

List any other surgeries ____
____

Review of Systems. Please check all that may apply to you:

___ Recent Wt Change
___ Fever/Chills/Sweats
___ Blurred Vision
___ Glaucoma
___ Hearing Loss
___ Ringing In Ears
___ Mouth Sores/Ulcers
___ Palpitations
___ Chest Pain
___ Shortness of Breath
___ Wheezing
___ Chronic Cough
___ Hoarseness
___ Spitting up Blood
___ Burning with Urination
___ Blood in Urine
___ Fatigue
___ Swelling of Ankles
___ Joint Pain or Swelling
___ Back Pain
___ Muscle Pain
___ Rash
___ Itching
___ Numbness/Tingling
___ Memory Loss
___ Depression
___ Excessive Thirst/Urination
___ Bleeding/Bruising Tendencies
___ Anemia
___ Past Blood Transfusion
___ Difficulty/Painful Swallowing
___ Heartburn/Indigestion
___ Nausea/Vomiting
___Bloating/Belching
___ Regurgitation
___ Constipation
___ Diarrhea
___ Abdominal Pain
___ Change in Bowel Habits
___ Rectal Bleeding
___ Black Tarry Stools
___ IBS
___ History of GI Bleed
___ Esophageal Stricture
___ Rectal Pain
___ Headaches
___ History of Stomach Ulcers
___ Ulcerative Colitis
___ Crohn's Disease
___ Hepatitis/Jaundice
___ Reflux Disease
___ Pancreatitis
___ Arthritis
___ Gout
___ Heart Attack
___ Asthma
___ Emphysema/ COPD
___ High Blood Pressure
___ Diabetes
___ Stroke
___ Kidney Disease/Stones
___ Heart Valve Replacement
___ Heart Murmur
___ Cong. Heart Failure
___ Anxiety/Depression
___ HIV/AIDS
___ Seizures
___ Diverticulitis
___ Hemorrhoids

Please list any other medical problems that you may have that are not listed:
____

____

AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

TO: ____

By signing this form, I authorize you to use and disclose the protected health information described below.

PATIENT NAME: _______________________________ **DOB**____________________

The health information you may release subject to this authorization is as follows:

____

Release my protected health information to the following persons:

GULF COAST GASTROENTEROLOGY
104 CIRCLE WAY, STE. B
LAKE JACKSON, TX 77566
979-297-4033 OFFICE
979-297-0099 FAX

The reasons or purposes for this release of information are as follows:

____

This authorization shall be enforced and effective until the following date:

____

I understand that I have the right to revoke this authorization in writing at any time by sending a written notification to **William H. Sweatt, M.D.**

____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE: ____

____
WITNESS SIGNATURE

Insurance Information

(Primary Insurance Info)

Patient Name: ___________________________ DOB:________________

INS. CO. Name____

INS. CO. Address: ____

Member ID: _____________________Group #________________________

Phone # ______________________________

Policy Holder's Name ___________________________DOB:___________

SS # __________________________ Relationship: ___________________

(Secondary Insurance Info)

Patient Name: ___________________________ DOB:_______________

INS. CO. Name____

INS. CO. Address____

Member ID: _____________________Group # ______________________

Phone # _____________________________

Policy Holder's Name__________________________ DOB: ____________

SS# _______________________ Relationship____________________

(Tertiary Insurance Info)

INS. CO. Name:________________________________

Gulf Coast Gastroenterology
104 Circle Way Ste. B
Lake Jackson, Tx 77566
(979) 297-4033 Office (979) 297-0099 Fax

Privacy Officer: Kate Falls, Office Manager Effective Date: 01/09/2006

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentially 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 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 records, 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 billing services), 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 discloses. Not every possible use or disclosure in a category is listed.

For Treatment
We may use medical information about you to provide you with medical treatment or services. Example: in treating you with 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 Options.
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.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization
. As required during as investigation by law enforcement agencies
. To avert a serious threat to public health or safety
. As required by military command authorities for their medical records
. To worker's compensation or similar programs for processing of claims
. In response to a legal proceeding
. To a coroner or medical examiner for identification of a body
. If an inmate, to the correctional institutions or law enforcement official
. As required by the US Food and Drug Administration (FDA)
. Other healthcare providers' treatment activities
. Other covered entities and providers payment activities
. Other covered entities healthcare operations activities (to the extent permitted under HIPAA)
. Uses and disclosures required by law
. Uses and disclosures in domestic violence or neglect situations
. Health oversight activities
We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
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 authorization to use or disclose medical information about you, you may revoke that authorization in writing, at any time. If you revoke your authorization, we will thereafter no longer use or are unable to take back any disclosures about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, 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 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.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

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 heath care professional chosen by this practice will review your request and the denial. The person conducting the

interview 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 and 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 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 Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example: on paper or electronically). The first list you request within a 12- month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

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.

Gulf Coast Gastroenterology, PA
104 Circle Way, Ste. B
Lake Jackson, Texas 77566
(979) 297-4033

Notice Of Privacy Practices
Patient Acknowledgement

Patient Name: ____________________________________

Date of Birth: ____________________________________

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____

Date: ____

Relationship to patient (if signed by a personal representative of patient): ____

Gulf Coast Gastroenterology
104 Circle Way, Ste. B • Lake Jackson, TX 77566
(979) 297-4033

********VERY IMPORTANT INFORMATION********

IF YOUR COLONOSCOPY HAS BEEN SCHEDULED FOR A SCREENING (MEANING YOU HAVE NO SYMPTOMS WITH YOUR BOWELS)*, AND YOUR DOCTOR FINDS A POLYP OR TISSUE THAT HAS TO BE REMOVED DURING THE PROCEDURE, THIS COLONOSCOPY IS <u>NO LONGER CONSIDERED A SCREENING COLONOSCOPY PROCEDURE,</u> IT IS NOW CONSIDERED A SURGICAL/DIAGNOSTIC PROCEDURE AND YOUR INSURANCE BENEFITS MAY CHANGE. PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO STARTING THE BOWEL PREPARATION.

***SYMPTOMS SUCH AS CHANGE IN BOWEL HABITS, DIARRHEA, CONSTIPATION, BLEEDING, ANEMIA, PAIN, ETC.**

____

SIGNATURE

____

DATE

____

WITNESS