Hernando Gastroenterology Associates

Ramakrishna P. Kanuri, M.D., Christopher Packey M.D., P.hD
Arlene Bradford APRN, Mackenzie Rich APRN
Diplomate American Board of Internal Medicine and Gastroenterology

"Competent care with compassion"

PATIENT REGISTRATION FORM

Last Name: ________________________ First Name: __________________________ Middle Initial______

Male___ Female ___ Date of Birth: _______________ Marital Status: Single Married Divorced Widow (circle one)

Race ___________Ethnicity____________________Preferred Language________________________

Address: _____________________________________City__________________ State ___ Zip _________

Home Phone: _______________ Mobile Phone: _______________ Social Security# ___________________

Pharmacy Name: ____________________________________ Phone: ____________________________

Referring Physician: _________________________________ Phone: ______________________________

Primary Care Physician: ______________________________ Phone: ______________________________

Place of Employment: ________________________________ Phone: ______________________________

Primary Insurance __________________ Policy # ____________________________Copay_______________

Secondary Insurance_________________ Policy #____________________________Copay_______________

Email address: ______________________@______________________________

Nearest Relative or Person we may contact in case of an Emergency

Name: _____________________________________ Relationship__________________________________

Address: ___________________________________ Telephone #: _________________________________

Assignment of Benefits Authorization for Treatment:

I hereby authorize treatment and authorize direct payment of surgical/medical benefits to Hernando Gastroenterology Associates for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

PRINT PATIENT NAME: ____

SIGNATURE: _______________________________________DATE: _________________________

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is "friendly" version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files are stored in our Electronic Medical Records System. These records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
10. I understand my medical care may require a physical exam and by signing I give my consent to any and all medically appropriate examinations (that may include a rectal exam) now and any future visits.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

(PRINT NAME) ______________________________ **Date**____________________
(SIGNATURE) ______________________________

Hernando Gastroenterology Associates

12190 Cortez Blvd, Brooksville, FL 34613 (352)597-1206 Fax (352-597-1208

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Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

I, ___________________________________, authorize **Hernando Gastroenterology Associates**

to release and obtain my private health information to/from (check all that applies):

Name____Relationship_______________________________

Name____Relationship_______________________________

Are there any restrictions on (PHI) Protected Health Information to be disclosed: ____Yes ____ No If yes: ______________________________

______No one other than myself may have access to my medical records

May our office leave a message on your machine: ____ Yes ____ No PHONE NUMBER_____________________

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am patient of **Hernando Gastroenterology Associates.**

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Privacy Officer at 12190 Cortez Blvd, Brooksville, FL 34613. I understand that my revocation will not affect any actions taken Hernando Gastroenterology Associates prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed, or until revoked in writing. At which time this authorization to obtain and release this protected health information expires.

____ ____________________
Patient Signature or Authorized Representative and relationship Date

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Patient History

Have you ever had?	No	Yes		No	Yes	Are you experiencing?	No	Yes
Hypertension			Hepatitis			Chills		
Chest pain			Diabetes			Fever		
Heart Attack			Anemia			Shortness of Breath		
Irregular Heartbeat			Gout			Epilepsy		
Pacemaker			Thyroid Disease			Numbness		
Glaucoma			Phlebitis			Extremity weakness		
Asthma			Stroke			GI Disorder		
COPD/Emphysema			Cancer			Ulcer		
Liver Disease			High cholesterol			Mental Illness		
Kidney Disease			Heart Disease			Bleeding Disorder		
Hemorrhoids			Rectal Itch			Rectal Bleeding/Pain		

Hernando Gastroenterology Associates has moved to Electronic Medical Records (EMR). In order to comply with "meaningful use", we are asking our patients to fill out the following questionnaire.

Race: Check One

	American Indian		Alaskan Native		Asian
	African American		White		Native Hawaiian/Pacific Islander
	Decline to report/Unreported				

Ethnicity: Check one

	Hispanic/Latino		Non Hispanic/Latino		Decline to report/Unreported

Nationality________________________________ **Decline to Report**________________________________

Primary Language__________________________ **Decline to Report**________________________________

Social History	Current	Past	How Much?
Alcohol			
Illegal Drug Use			

Please Check Correct Box

Tobacco	Every day Smoker______	Some day Smoker_______	Former Smoker______	Never Smoked______
Caffeine	Cups Daily_____	Cups____________	Cups___________	Cups___________

Patient Signature: ____ Date: ______________________

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MEDICATION LIST

Patient Name: ________________________ Date: ________________

Medication Name	**Strength**	**How taken**
Surgeries & Date:	**Height:**	**Allergies:**
	Weight:	

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