



PATIENT DATA
FORM MUST BE COMPLETED IN FULL

Today's Date _____

Patient's Legal Name _____ Goes By or Nickname _____

Date of Birth _____ Gender Male Female

Home Address _____
Street Apartment/Unit # City State Zip

Preferred Numbers: Primary (home or cell) _____ Work _____ Email _____

Preferred Language English Arabic Chinese French Hindi Portuguese Russian
 Spanish Vietnamese Unknown Declined Other _____

Race American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Other Pacific Islander White
 Other Race Unknown Declined

Ethnicity Hispanic or Latino Non-Hispanic or Latino Declined

PARENT / GUARDIAN INFORMATION

Mother/Guardian Name _____ Date of Birth _____

Home Address (if different than above) _____
Street Apartment/Unit # City State Zip

Preferred Numbers: Primary (home or cell) _____ Work _____ Email _____

Father/Guardian Name _____ Date of Birth _____

Home Address (if different than above) _____
Street Apartment/Unit # City State Zip

Preferred Numbers: Primary (home or cell) _____ Work _____ Email _____

Minor child lives with Both Parents Mother Only Father Only Other _____

If parents are not married, who has primary legal custody? Mother Father Other _____

Are there legal documents indicating who is responsible for health coverage? Yes No
 If yes, who is responsible for health coverage? _____

Primary Care Physician/Pediatrician _____ Referring Physician _____

Street Suite City State Zip Phone Street Suite City State Zip Phone

EMERGENCY CONTACT

Name & Relationship _____ Daytime Phone _____

INSURANCE INFORMATION

Primary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

Secondary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____
Street Suite City State Zip

I authorize AGA to communicate electronically with our preferred pharmacy to obtain the patient's prescription history. Yes No

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent for the patient to be treated by the staff and providers of AGA, LLC, and its affiliates. I authorize payment of medical benefits to AGA, LLC and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Parent / Legal Guardian Signature _____ Date _____

AGA, LLC d/b/a Atlanta Gastroenterology Associates ("AGA") and its affiliated companies comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. AGA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AGA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, ask to speak to the site manager.

If you believe that AGA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: AGA, LLC, ATTN: Compliance Officer, 550 Peachtree St NE, Ste 1600, Atlanta, GA 30308, (phone) 404.888.7575, (fax) 404.253.6896, or (email) hipaacompliance@atlantagastro.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1.800.368.1019, 800.537.7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

AGA offers language services free of charge to those patients requiring assistance.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም ኣርዳታ ድርጅቶቻች: በነጻ ሊያገኙዎት ተዘጋጅተዋል:

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

توضوح: إذا كنت تتحدث تنك اذنا، قد نساعدك على فهم ما تقوله، دون أي رسوم.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.

امش یارب ناگیار تروصب ی نابز تالی هست، دینک یم وگتفگ ی سراف نابز هب رگا: هجوت

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。

Today's Date _____

Patient's Name _____ Age _____ Date of Birth _____ Male Female

Referred by _____ Primary Care Physician _____

Describe the reason(s) for the visit _____

How long have symptoms persisted? _____ If a change in weight (loss/gain), list amount _____

1) MEDICAL HISTORY

Please check all that apply.

- | | | | |
|------------------------------------|---|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pancreatitis | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Autism | <input type="checkbox"/> GERD | <input type="checkbox"/> Thyroid Disease | |

List additional medical problems or illnesses including cancers and psychiatric treatment.

2) VACCINES

Is patient up-to-date on vaccines? Yes No

3) LABORATORY TESTS

Check and provide most recent dates if patient has had any of the following labs. *Provide a copy of any lab or test results.*

Blood Work _____ Stool Study _____ Urine _____

4) HOSPITALIZATION AND SURGICAL HISTORY

Check all that apply including age and date of procedure or hospitalization.

- | | |
|--|--|
| <input type="checkbox"/> Adenoidectomy _____ | <input type="checkbox"/> Hernia Surgery _____ |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Myringotomy (Ear Tubes) _____ |
| <input type="checkbox"/> Brain Surgery _____ | <input type="checkbox"/> Nissen Fundoplication _____ |
| <input type="checkbox"/> Colon Surgery _____ | <input type="checkbox"/> Small Intestine Surgery _____ |
| <input type="checkbox"/> Colonoscopy _____ | <input type="checkbox"/> Spinal Surgery _____ |
| <input type="checkbox"/> Fracture Surgery _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> G-Tube _____ | <input type="checkbox"/> Transplant Surgery _____ |
| <input type="checkbox"/> Gallbladder Surgery _____ | <input type="checkbox"/> Upper Endoscopy (EGD) _____ |
| <input type="checkbox"/> Heart Surgery _____ | <input type="checkbox"/> Other _____ |

5) IMAGING

Check and provide most recent dates if patient has had any of the following imaging services recently.

- | | |
|---|---|
| <input type="checkbox"/> Barium Swallow _____ | <input type="checkbox"/> Ultrasound _____ |
| <input type="checkbox"/> CT Scan _____ | <input type="checkbox"/> X-ray _____ |
| <input type="checkbox"/> MRI _____ | <input type="checkbox"/> Other _____ |

6) MEDICATIONS

List current medications (including herbal, supplements and over-the-counter) and dosage

I authorize Atlanta Gastroenterology Associates to obtain the patient's prescription history electronically. Yes No

Is patient currently taking any of the following aspirin/NSAIDs? Advil Aleve BC Powder
 Goody's Powder Ibuprofen Naprosyn

List medication, food, environmental and latex allergies including reactions to each

Does the patient have a personal history and/or is there a family history of problems with anesthesia? Yes No

7) CURRENT DIETS

For infants Breast fed Formula fed Both Current formula _____ Formulas attempted _____
One year and older Regular diet Special diet List details _____

8) SOCIAL HISTORY

List all people that live in the same home as patient _____

Is patient adopted? Yes No Is patient in foster care? Yes No

What grade is patient in? _____ Is patient missing school? Yes No If yes, how many days per month? _____

Is patient missing school activities? Yes No If yes, list school activities _____

List any recent travel (list destination and dates) _____

List the types of animals patient is around regularly _____

List any family stressors (Examples: financial, marital, death, school issues) _____

Alcohol (beer, wine, liquor) Never Former Current (Every Day) Current (Some Days) Current (Unknown)

Tobacco (cigarettes, cigars, chewing tobacco) Never Former Current (Every Day) Current (Some Days) Current (Unknown)

9) BIRTH HISTORY

Birth Weight _____ Birth Length _____ Full-Term Pre-Term Delivered at week # _____

Type of Delivery Vaginal Caesarean

List any pregnancy or delivery difficulties _____

10) **SYSTEMS REVIEW:** Does patient currently have or has recently experienced any of the following? Note if a family member is experiencing or has any of the following. (Family members include parents, siblings, grandparents, aunts, uncles and cousins.)

EYES	Patient	Relative	Relation	GASTROINTESTINAL, <i>continued</i>	Patient	Relative	Relation
Visual Changes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Unintentional Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
HENT				GENITOURINARY			
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____	Female patients, date of last period _____			
Mouth Ulcers/Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____	Burning with Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____	Recent/Frequent Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor Dentition	<input type="checkbox"/>	<input type="checkbox"/>	_____				
CARDIOVASCULAR				SKIN			
Arrhythmias (irregular heartbeat)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dermatitis or Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____	Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaundice (yellow eyes or skin)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mitral Valve Prolapse or Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____				
RESPIRATORY				NEUROLOGIC			
Aspiration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Autism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Croup	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____				
RSV	<input type="checkbox"/>	<input type="checkbox"/>	_____	MUSCULOSKELETAL			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Pain/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus, Scleroderma, Related Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL				ENDOCRINE			
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal Fissures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Inborn Errors of Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal/Rectal Pain or Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Black Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____	PSYCHIATRIC			
Bloating/Belching/Gaseousness	<input type="checkbox"/>	<input type="checkbox"/>	_____	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	_____	LYMPHATIC/HEMATOLOGY			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea/Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty in Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Enlarged Nodes/Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallstones/Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALLERGY/IMMUNOLOGY			
Gastrointestinal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____	Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn/GERD	<input type="checkbox"/>	<input type="checkbox"/>	_____	OTHER			_____
Intestinal Polyps	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Mucus in Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Parent / Legal Guardian Signature _____ Date _____

My signature below confirms I have reviewed the above with the patient/family.

Physician Signature _____ Date _____



FINANCIAL DISCLOSURE STATEMENT

Date _____

Patient Name _____ (please print) Patient Date of Birth _____

Parent /Legal Guardian Name _____

Thank you for choosing AGA, LLC (AGA). Please read and sign this Financial Disclosure Statement prior to the patient’s appointment. Guarantors who do not pay in full at the time of service must complete the required information and insurance forms before service will be rendered.

You can expect to receive the following bills as a result of the patient’s visit:

- **Physician Fee:** Fee to be paid to the physician for performing the service. This bill will be from AGA, LLC, AGA Clinical Services, LLC, or AGA Professional Services, LLC.
- **Lab Fee:** If a lab test is ordered, a second bill will come from a lab or a radiologist.

Some insurance companies require precertification for this service. We will make every effort to verify benefits and obtain any necessary precertification prior to your appointment. This is not a guarantee of payment.

The insurance company will send you an Explanation of Benefits that will explain how the bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand the insurance benefits.

Some insurance plans require you to pay different out-of-pocket amounts based on the location where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. We will submit primary and secondary claims on the patient’s behalf as long as the information needed to process the claim is obtained and verified before the visit. If this information is obtained after the visit or if the information provided is deemed inactive for the dates of service, the guarantor is responsible for the balance.

We accept cash, checks and major credit cards. AGA and its affiliates collect co-payments at the time of service. Additional payment may be required based on your insurance plan. For all outstanding balances, AGA will send statements to the responsible party’s address. If there is a balance due at any affiliate of AGA, LLC, including AGA Clinical Services, LLC or AGA Professional Services, LLC, your payment will be applied to the oldest balance first. In the event the account has a credit for one affiliate of AGA and a deficit for another, we reserve the right to transfer credits to any outstanding balances prior to issuing a refund.

Additional questions regarding billing or payment arrangements should be directed as follows:

- **For an upcoming visit,** call the office and ask to speak to the financial counselor.
- **For previous visits,** call 678.223.7788.

If the patient is unable to keep the appointment, please reschedule at least 48 hours in advance. A missed appointment will result in a \$25 fee. A \$30 fee will be incurred for returned checks.

Divorced Parents: In cases of divorce or separation, the parent authorizing treatment/services for the minor patient will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the charges, it is the authorizing parent’s responsibility to collect from the other parent. Neither AGA nor its affiliates will mediate payment between parents.

PATIENT’S REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices of AGA, LLC and its affiliates and that I may receive multiple bills related to services as explained above. I authorize payment of medical benefits to AGA, LLC and its affiliates and authorize them to release any medical information necessary to process claims. I give AGA, LLC permission to apply payments received to balances due at AGA, LLC, including AGA Clinical Services, LLC or AGA Professional Services, LLC, and understand that payments will be applied to the oldest balance first. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by the patient’s health plan.

Parent/Legal Guardian Signature Date _____

Witness Date _____

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.

AGA, LLC and its affiliates ("AGA") present this Notice of Privacy Practices ("Notice") to our patients describing how your identifiable medical information (called protected health information or PHI) may be used or disclosed, and to notify you of your rights regarding this information.

Patient Protected Health Information

Under Federal law, your patient health information is protected and confidential. Protected health information (PHI) 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 Protected Health Information

AGA uses health information about you for treatment, analyzing procedures and lab results. We also use PHI to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances where the law applies, we may be required to use or disclose the information without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: AGA will use and disclose your PHI to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your medical record and use it to determine the most appropriate course of care. AGA may also disclose this information by fax, in person, or via telecommunication. We may communicate to other health care providers who are participating in your treatment, to pharmacists who are filling and refilling your prescriptions, and to family members who are helping with your care.

Payment: AGA will use and disclose your PHI for payment purposes. For example, AGA may need to obtain authorization from your insurance company before providing certain types of treatment. AGA will submit bills and maintain records of payments from your health plan.

Health Care Operations: AGA will use and disclose your health information to conduct our standard internal operations. Examples include proper administration of records, evaluation of the quality of treatment, and assessing the care and outcomes of your case and others like it.

Release of Information to Family or Friends

AGA knows that family or friends are an integral part of a patient's care. If you wish to authorize a family member or friend to receive or request information regarding your care or test results, please provide their name and contact information on the 'Notice of Privacy Practices Acknowledgement' form. AGA will not release your information to any friend or family without your written consent. If you wish to change or update the authorized individuals, you will need to make these updates in writing.

Special Uses

AGA may use your information to contact you with appointment reminders by phone, mail, email, or text message. AGA may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. This communication may be sent to you via phone, mail, or email. If you have granted written permission, protected health information may also be sent to you via email. If you wish to authorize the use of email as a method for AGA to communicate with you regarding your PHI, sign the proper section on the 'Notice of Privacy Practices Acknowledgement' form.

Health Information Exchange

Your information may be shared with other healthcare providers via Health Information Exchange (HIE). AGA is currently participating in the Georgia Health Information Network (GaHIN) HIE.

- **Function of the HIE**

The function of the HIE is to improve patient-centered healthcare through the use and exchange of electronic health information. This collaborative effort seeks to close the patient information gap by allowing authorized healthcare providers to share their patients' records on an as-needed basis to support improved quality of care and patient health outcomes, as well as reduce patient healthcare costs.

- **Types of Data Exchanged**

Members of the HIE share electronic health records, which may include your medical history, allergies, radiology, labs, doctors' notes and/or immunizations. Sensitive information that requires specific written authorization to disclose will not be shared through the HIE; this includes mental health and psychotherapy records. In the event that you want this type of sensitive information shared, an express written consent will be required for each release. However, sensitive health information, including, but not limited to: substance abuse records, HIV/AIDS information, genetic testing, and developmental disability records may be viewed through the HIE unless you opt-out of the HIE (See "Opting Out" section).

- **Permitted Disclosures**

The HIE ensures protection of patients' personal information by limiting use of patient health data to ensure meaningful use, as described in the "How We Use Protected Health Information" section of this document. In addition, state agencies may only request, receive, use and disclose patient health data solely as authorized by applicable law, or as legally authorized by the individual.

- **Opting Out**

You have the choice to opt-out of having your electronic records viewed by participating members of the HIE at any time, by completing the opt-out form, which will be provided upon request. If you choose to opt-out of the HIE, your electronic health records cannot be viewed or shared with other healthcare providers using the network. However, authorized healthcare providers will still be able to access your health information on an as-needed basis to assist with continued care via phone, fax and/or regular mail. Until you submit a completed opt-out form, or provide written notice that you are opting not to participate in the HIE, your electronic information is subject to be viewed amongst authorized members of the HIE utilizing the system. Once received, it may take up to five business days to process the request. It is important to note that if another provider who treats you is a member of the HIE, if you do not opt-out with that provider, your information may still be viewed and shared via the HIE.

- **Opting Back In**

In the event that you choose to have your electronic records viewed by participating members of the HIE after opting out, you may simply choose to opt-out at any time by providing a written request. It is important to note that if you choose to opt-out of having your electronic records shared via the HIE, none of your electronic records will be viewable via the HIE until you provide AGA written notification expressly consenting to your electronic records being shared via this method.

- **Potential Risks and Benefits of HIE Participation**

- **Benefits**

Participation provides patients with several benefits, including: quick, secure and accurate sharing of patient information among authorized healthcare providers for improved and efficient patient care; reduction of duplicate medical tests; expedited information retrieval, increasing patients' face-to-face time with providers; and enhancing accuracy and efficiency in patient care.

- **Risks**

There are limited risks associated with your participation in the HIE. The risks are managed through HIE policies and federal HIPAA regulations, by which all participants must abide. You have a right to receive a list of occurrences that your health information was accessed, as well as for what purpose, as described in the "Accounting of Disclosures" section of this document. In the event there is a breach of security which involves your health information, you will be notified per HIPAA regulations.

Other Uses and Disclosures Not Requiring Written Permission

AGA may use or disclose your protected health information for other reasons, even without your consent. Subject to certain requirements, AGA is permitted to give out health information without your permission for the following purposes:

- **Required by Law**

AGA may be required by the law to disclose your PHI for certain purposes, such as reporting gunshot wounds, suspected abuse or neglect, or similar injuries and events.

- **Research**

AGA may use or disclose information for approved medical research subject to specific criteria.

- **Public Health Activities**

As required by law, AGA may disclose vital statistics, diseases, proof of immunization, information related to recalls of dangerous products, and similar information to public health authorities.

- **Health Oversight**

AGA may be required to disclose information to assist in investigations and audits; eligibility for government programs; inspections; licensure or disciplinary actions; compliance to civil rights laws; and similar activities.

- **Judicial and Administrative Proceedings**

AGA may disclose information in response to an appropriate subpoena or court order.

- **Law Enforcement Purposes**

Subject to certain restrictions, AGA may disclose information required by law enforcement officials.

- **Deaths**

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

- **Serious Threat to Health or Safety**

AGA 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, AGA may release information as required by military command authorities. AGA may also disclose information to correctional institutions or for national security purposes.

- **Workers' Compensation**

AGA may release information about you as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will 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. Submit any concerns in writing to AGA's Compliance Officer (see below).

- **Request Restrictions**

You may request restrictions on certain uses and disclosures of your health information. These requests must be in writing. AGA is not required to agree to most restrictions, but if we do agree, AGA must abide by those restrictions.

- **Restrict Disclosure to a Health Plan**

You may request, in writing, to restrict disclosure of your PHI to a health plan. For example, you may request in writing that you choose not to use your insurance for a specific visit. If the request is made in writing in advance, the healthcare service or item is paid in full at the time of service, and the disclosure is for payment or healthcare operations, AGA must agree to the restriction except for cases where the disclosure is required by law. (i.e., your health plan requires all healthcare services to be disclosed or filed.)

- **Confidential Communications**

You may ask us to communicate with you confidentially including by reasonable alternate means or locations. This request must be made in writing. There may be conditions placed on accommodating the request in certain situations.

- **Inspect and Obtain Copies**

You have the right to see or receive a copy of your health information. There may be a small charge dictated by Georgia Law for these copies. You may obtain a copy of your health information by completing and submitting a medical records release form. By law, you must receive the requested information within 30 days.

- **Amend Information**

If you believe information in your record is incorrect, you have the right to request that AGA correct or amend the existing information. The request must be made in writing and include a reason to support the requested amendment. Your AGA physician has the right to refuse your request. Regardless, a letter concerning your request will be sent within 60 days of said request.

- **Accounting of Disclosures**

You may request a list of instances where we have disclosed health information about you within the last six years for reasons other than treatment, payment, or health care operations. This request must be submitted in writing. The request must be fulfilled within 60 days. If AGA is unable to fulfill the request within 60 days, the law grants a one-time 30 day extension. A written statement regarding the reason for the delay will be provided to you. If you request an accounting more than once in a 12 month period, AGA may impose a reasonable cost-based fee for each subsequent request.

- **Obtain Paper Copy of Notice**

If you have previously received this Notice in electronic form, you have the right to request a paper copy of this Notice.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We are also required by law to notify you in the event of a breach of your unsecured PHI.

Changes in Privacy Practices

We may change our policies at any time. A current version of our Notice is available on AGA's website. A current summary version of our Notice is available in each waiting area at all times. You may also request a copy of the current version of our Notice at any time. Any changes to our privacy practices described in this Notice will apply to all PHI created or received prior to this revision. For more information about our privacy practices, submit concerns in writing to AGA's Compliance Officer (see below).

Complaints

If you are concerned that we have violated your privacy rights, if you disagree with a decision we made about your records, or would like to file a complaint, contact the person listed below. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

If you have any questions, requests or complaints regarding privacy rights, please contact AGA's Compliance Officer:

Mailing Address:

AGA, LLC
ATTN: Compliance Officer
550 Peachtree St NE, Suite 1600
Atlanta, GA 30308

Phone: 404.888.7575

Email: HIPAAcompliance@atlangastro.com

Website: Use Contact Form, category "HIPAA Compliance/Privacy"



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT

I, _____, hereby acknowledge that AGA, LLC and its affiliates have given me the opportunity to read a detailed notice of their Privacy Practices.

Patient/Authorized Representative Signature * If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian. Date _____

If not signed, please provide a reason why the acknowledgement was not obtained.

Witness / Staff Signature Date _____

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from AGA, LLC and its affiliates to share information regarding care or tests results with the individuals listed below. These individuals may also request protected health information on my behalf.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Is it OK to leave results or protected health information on your voicemail? Yes No

I recognize that AGA, LLC and its affiliates may share my protected health information with other healthcare providers, including sensitive health information such as: HIV/AIDS information, substance abuse records, genetic testing information, and developmental disability records. This information may be shared with other healthcare providers via various methods, including but not limited to, fax or health information exchange.

NOTE: If you choose to opt out of having your information shared via health information exchange, you must request and complete an Opt-Out Form available at AGA offices.

Patient/Authorized Representative Signature * If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian. Date _____

CONSENT TO CORRESPOND ELECTRONICALLY

While AGA, LLC and its affiliates take reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with an AGA physician regarding medical care, the AGA physician and/or his/her representative has my permission to correspond via that email address.

I give permission for an AGA physician or clinical staff member to email me at _____ @ _____ regarding medical care.

Patient/Authorized Representative Signature * If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian. Date _____



AUTHORIZATION FOR OTHERS TO ACCOMPANY AND CONSENT TO TREAT MINOR PATIENT

Complete this form ONLY if the patient is authorized to attend future visits alone or with someone other than their parent/legal guardian.

Patient Name _____ Date of Birth _____

For the first office visit, we require that a parent or legal guardian accompany the patient. For future appointments, other individuals may bring the patient, as long as the parent has given written consent, and that consent is on file in our office. The authorized individuals are required to bring photo identification. In limited circumstances, the patient may come unaccompanied by an adult. If any of these situations apply, complete the applicable sections below. **This form must be notarized. For your convenience, a Notary Public is typically present in the Pediatric and Adolescent Office.**

AUTHORIZATION TO ACCOMPANY AND/OR CONSENT TO TREATMENT PATIENT

I hereby authorize the following individuals to bring the patient to AGA, LLC, for treatment and to exchange necessary information (including test results, care plan, etc.) with medical personnel. By checking the box next to the individual's name, I also grant this individual the right to give consent to medical treatment. This request will remain in effect for one year or until revoked by me in writing.

Name	Relationship to Patient	Authorization to Consent to Medical Treatment
1) _____	_____	<input type="checkbox"/>
2) _____	_____	<input type="checkbox"/>
3) _____	_____	<input type="checkbox"/>
4) _____	_____	<input type="checkbox"/>

LIMITATIONS

Identify any limitations on the kinds of medical services for which this consent by proxy is given. If none, state "none".

If medical care is of an urgent nature, please contact one of the parents/legal guardians listed below regarding the healthcare of the of minor patient listed above.

Parent/Legal Guardian _____ Primary Phone _____ Secondary Phone _____

Parent/Legal Guardian _____ Primary Phone _____ Secondary Phone _____

If you are unable to contact either parents/legal guardian, you may rely on the authorized individual who brought the child to the medical appointment.

PREAUTHORIZATION TO TREAT UNACCOMPANIED MINOR

I authorize the patient, listed above, to independently attend appointments and receive any treatment for which I previously provided consent.

I understand that I am financially responsible for all medical expenses incurred by the patient incurred during these appointments.

Parent/Legal Guardian Name _____

Parent/Legal Guardian Signature _____ Date _____

In witness whereof, the undersigned has executed this instrument as of the _____ day of _____, 20____.

Subscribed to and sworn before me this _____ day of _____, 20____.

Notary Public _____

My commission expires _____

[SEAL]