

ACKNOWLEDGMENT & CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from GAST ROCARE, P. C. (GRC) / TUSCALOOSA ENDOSCOPY CENTER (TEC). You agree that records concerning your care within GRC and/or TEC shall remain the property of TEC and/or GRC. You understand and agree that such information is used for: (1) your treatment – the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient, (2) payment for your services – billing, claims management, medical data processing, reimbursement, and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account, (3) routine healthcare operations – including, but not limited to, quality assurance, utilization review, medical review, internal auditing, medical research and educational purposes. You acknowledge that you have been provided with a GRC/ TEC Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand GRC/TEC reserves the right to change the Notice and GRC/ TEC will provide you with a revised Notice when you come to TEC/GRC. You have the right to request we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____

TEC/GRC: Agree _____ Do Not Agree _____ N/A _____

Signature of Patient

Date

**GASTROCARE, P.C. (GRC) AND
TUSCALOOSA ENDOSCOPY CENTER (TEC)**

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the information below.

I (we), the undersigned patient and/or responsible party hereby authorize GASTROCARE, P.C. / TUSCALOOSA ENDOSCOPY CENTER, it's physician's, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc to the person or persons indicated below:

_____ **Spouse** **Name** _____

_____ **Parent(s)** **Name(s)** _____

_____ **Children** **Name(s)** _____

_____ **Other** **Name(s)** _____

May we leave medical information on you answering machine? YES / NO

May we release medical information to an individual about your procedure, if they come with you for a procedure? YES / NO

Patient Signature: _____ **Date:** _____

******* _____ DO NOT DISCUSS OR RELEASE ANY OF MY
MEDICAL INFORMATION TO ANYONE EXCEPT MYSELF.**

**GASTROCARE, P.C. AND
TUSCALOOSA ENDOSCOPY CENTER**

A.B. Reddy, M.D., F.A.C.G., Henri de la Baume, M.D

Name: _____ Age: _____ Date: _____

Referring Doctor: _____

Chief Complaint: _____ Duration: _____

HPI: Abdominal Pain: (location, severity, duration, modif. Factors) Yes No

Weight Loss:	Yes	No	Vomiting:	Yes	No	Black Stool / Melena:	Yes	No
Diarrhea:	Yes	No	Blood in Vomitus:	Yes	No	Blood in Stool:	Yes	No
Constipation:	Yes	No	Heartburn:	Yes	No	Difficulty swallowing:	Yes	No
Nausea:	Yes	No	Loss of Appetite:	Yes	No			

Pertinent (Your) Past Medical History:

Cancer: Yes No Colon polyps: Yes No Peptic Ulcer: Yes No

Any other medical problems: Yes No Please list: _____

Any recent hospital admissions: Yes No

Operations: _____

Family History:

Cancer: Yes No Colon polyps: Yes No Peptic Ulcer: Yes No

Any other medical problems: Yes No Please list: _____

Social History:

Smoking: Yes No Alcohol Use: Yes No

ALLERGIES: _____

Current Medications: _____

ROS:

Constitutional:	Appetite:	Yes	No	Weight Gain:	Yes	No	Fever:	Yes	No
Cardiovascular:	Chest pain:	Yes	No	Irregular Heart:	Yes	No	Coughing up blood:	Yes	No
Respiratory:	Shortness of Breath:	Yes	No	Cough:	Yes	No	Kidney stone:	Yes	No
Genitourinary:	Difficulty Urinating:	Yes	No	Blood in Urine:	Yes	No			
Endocrine:	Diabetes:	Yes	No						
Psychological:	Stress Factors:	Yes	No						
Musculoskeletal:	Arthritis:	Yes	No	Lupus:	Yes	No	Fibromyalgia:	Yes	No
Gynecological:	Menses: Regular / Irregular			Last Menstrual Period:	_____		Endometriosis:	Yes	No

CNS:

**GASTROCARE, P.C. AND
TUSCALOOSA ENDOSCOPY CENTER**
Tuscaloosa, Alabama

A.B. Reddy, M.D., F.A.C.G., Henri de la Baume, M.D

AUTHORIZATION FOR TREATMENT

The undersigned has been informed of the treatment considered necessary for the patient whose name appears on the bottom and that the treatment and procedures will be performed by the above physician, and whomever he may designate as assistants. Authorization is hereby granted for such treatment and procedures.

The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.

Date	Printed Name of Patient
Witness	Signature of Patient or Authorized Person
	Relationship to Patient

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

Authorization is hereby granted to release to the Primary or Consulting / Referring Physician such information as may be necessary for the completion of my hospitalization claims.

|  |                                           |
|--|-------------------------------------------|
|  | Signature of Patient or Authorized Person |
|  | Relationship to Patient                   |

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AUTHORIZATION TO PAY THE PHYSICIAN / FACILITY

I hereby authorize payment for services provided in the office, endoscopy center and the hospital directly to the above physician, otherwise payable to me. I understand I am financially responsible for the medical and/or physician charges not covered by this authorization.

	Signature of Patient or Authorized Person
	Relationship to Patient

All authorizations must be signed by the patient, or by an authorized person in the case of a minor or when a patient is physically or mentally incompetent.