CUMBERLAND GASTROENTEROLOGY, P.S.C.

Patient Name: _____Age _____ Birthdate_____ Sex ___ M ___ F

Race □ White □ African American □ Hispanic □ Asian □ Refuse to report

Ethnicity □ White □ African American □ Not Hispanic □Hispanic □Refuse to report

Language □English □Hispanic □ Other □ Refuse to report

Address_____City/State/Zip_____

Social Security # _____ Married ____ Single _____ Divorced _____ Widowed _____

Home Phone (_____) _____ Cell Phone (_____) _____

Email address: _____

Employer _____ Address _____

Work Phone (_____) _____ ext _____

Spouse's Name _____ Birth date _____ Social Security # _____

Employer _____ Work Phone _____ ext _____

**May we speak to your spouse regarding your protected health information? ___ Yes ____ No

IF *PATIENT IS UNDER 18* YEARS OF AGE, COMPLETE THIS SECTION

Father's Name _____ Birth date _____ Social Security # _____

Employer _____ Work Phone _____ ext _____

Mother's Name _____ Birthdate _____ Social Security # _____

Employer _____ Work Phone _____ ext _____

Who is your primary care physician? _____ Who referred you to our office: _____

Please **list names and contact phone numbers of people we have permission to speak to on your behalf:

_____

INSURANCE INFORMATION:

Primary Insurance _____ **Secondary Insurance** _____

Who Carries the insurance_____ Who Carries the insurance_____

Date of Birth of insured _____ Date of Birth of insured__ _____

What Prescription Drug Plan do you have: (such as Medco, Sure scripts, etc.) This is needed to be able to give you medications that are covered by your insurance _____Mailing address/Telephone _____

I have read the HIPAA Notice of Privacy Practices. I authorize Cumberland Gastroenterology to furnish information concerning my present illness. I direct the insurer to pay to the physician, all benefits due him as a result of this claim. Although covered by the insurance, I am personally responsible for all charges. A photocopy of this authorization will be valid as the original. Please be advised Dr. Cook/Dr. Bryson and Dr. Horn have ownership interest in Lake Cumberland Surgery Center, as do most of the physicians who work there.

Signature of Patient/Parent/Guardian _____ Date _____

PATIENT QUESTIONNAIRE

Patient Name: _____ Birthdate: _____ Today's Date _____

Do you Have these symptoms:

CONSTITUTIONAL
Recent weight change _____No ___ Yes
Fever _____No ____Yes
Fatigue _____No ____ Yes

EYES
Blurred Vision ____ No ____ Yes
Glaucoma ____ No ____ Yes

EARS, NOSE, MOUTH, THROAT
Hearing loss ____ No ____ Yes
Ringing in ears ____ No ____ Yes
Mouth sores ____ No ____ Yes

CARDIOVASCULAR
Chest Pain ____ No ____ Yes
Shortness of Breath ____ No ____ Yes
Swelling of ankles ____ No ____ Yes

RESPIRATORY
Chronic Cough ____No ____ Yes
Spitting up blood ____No ____ Yes
Wheezing ____ No ____Yes

GENITOURINARY
Burning with urination ____ No ____Yes
Blood in Urine ____ No ____Yes

MUSCULOSKELETAL
Joint pain or swelling ____ No ___ Yes
Back pain ____ No ___ Yes
Muscle pain ____ No ___ Yes

SKIN
Rash ___ No ____ Yes
Itching ___ No ____ Yes

GASTROINTESTINAL
Poor Appetite ____ No ___ Yes
Difficulty Swallowing ____ No ___ Yes
Heartburn ____ No ___ Yes
Nausea or Vomiting ____ No ___ Yes
Bloating ____ No ___ Yes
Belching ____ No ___ Yes
Regurgitation ____ No ___ Yes
Constipation ____ No ___ Yes
Diarrhea ____ No ___ Yes
Abdominal Pain ____ No ___ Yes
Change in bowel habits ____ No ___ Yes
Rectal bleeding ____ No ___ Yes
Black, tarry stools ____ No ___ Yes

NEUROLOGICAL
Headaches ____ No ___ Yes
Seizures ____ No ___ Yes
Strokes ____ No ___ Yes
Numbness ____ No ___ Yes

PSYCHIATRIC
Memory loss ____ No ___ Yes
Depression ____ No ___ Yes

ENDOCRINE
Heat or cold intolerance ____ No ___ Yes
Excessive thirst/urination ____ No ___ Yes

HEMATOLOGICAL
Bleeding or bruising tendency ____ No ___ Yes
Anemia ____ No ___ Yes
Past transfusion ____ No ___ Yes

Are you pregnant? ____ No ___ Yes

Which other medical **conditions** do you have?

___ Hiatal Hernia
___ Gastritis
___ Kidney Stone
___ Ulcerative colitis
___ Ulcers
___ Arthritis
___ Anemia
___ Asthma
___ Kidney Failure
___ Polyps
___ Crohn's disease
___ Diabetes
___ Tuberculosis
___ Cystic Fibrosis
___ Reflux
___ Jaundice
___ Rheumatic Fever
___ Heart conditions
___ Hemorrhoids
___ Stroke
___ Mental Retardation
___ Barrett's Esophagus
___ Jaundice
___ Diverticulitis, irritable bowel
___ Physical disability
___ High blood pressure
___ HIV
___ Hepatitis

Have you ever Smoked? ___ No ___ Yes
# of packs per day _____
# of years smoked _____

Have you ever used alcohol? ___ No ___ Yes
# of drinks per week? _____

When did you quit? _____

Do you have allergies: ___ No ___ Yes _____

Do you have Drug allergies: ___ No ___ Yes _____

Are Immunizations up to date: ____ No ___ Yes

Do you have routine screening procedures? _____ No _____ Yes

Please list all medications (including over the counter, vitamins or herbal preparations), dosage and how long you have been taking the medicine: (You do not need to bring these with you when the list is complete)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PHARMACY NAME_____ TELEPHONE NUMBER_____

List all surgeries, endoscopies, x-rays and the ***year*** these were performed:

_____ _____
_____ _____
_____ _____
_____ _____

Have you ever experience an adverse reaction to sedation or anesthesia? ___ No ___ Yes
Do you have Malignant Hyperthermia? ___ No ___ Yes
If yes, for what procedure: _____

FAMILY HISTORY – Please check all that apply to your family history -

	Father	**Mother**	**Siblings**	**Other**
Colon Cancer	_____	_____	_____	_____
Colon Polyps	_____	_____	_____	_____
Ulcers	_____	_____	_____	_____
Uterine/Endometrial/ Ovarian Cancer	NA	_____	_____	_____
Liver Disease	_____	_____	_____	_____

Cumberland Gastroenterology, P.S.C.
(606) 677-2913 Fax: (606)677-6983

Authorization for Release of Information

Signed authorization is necessary to release or obtain medical records. By signing this authorization you are giving Cumberland Gastroenterology permission to release/obtain medical records pertinent to your continued care.

Patient Name: _____
First Middle Initial Last Maiden or Other Name
Date of Birth: _____ SS: _____

Address: _____
Street address City, State and Zip Code
Day Phone _____ Evening phone _____

I hereby authorize Cumberland Gastroenterology to ***obtain*** information from my medical record from _____as indicated below to:

Information to be released/requested may include:

- ☐ History and Physical exam
- ☐ Progress Notes
- ☐ Lab reports
- ☐ X-ray reports
- ☐ Operative note and Pathology
- ☐ Substance Abuse including alcohol/drug abuse
- ☐ Mental Health including psychotherapy notes
- ☐ HIV related information (AIDS related testing)
- ☐ Other_____
- ☐ All Records

I authorize Cumberland Gastroenterology to ***release*** information from my medical record to:
_____.

I request my records to be ☐faxed to _____ ☐ electronically sent ☐pick up paper copy

Purpose of Disclosure: ☐ Continued Care ☐ Consultation/second opinion ☐ Insurance
☐ Changing Physicians ☐ Legal ☐ Other (Please specify)
_____

1. I understand this authorization will expire in one year.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that I am being requested to release this information by Cumberland Gastroenterology for the purpose of medical care.
    a. By authorizing this release on information, my health care and payment for my health care will not be affected if I do not sign this form.
    b. I understand I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.
    c. I have been informed that Cumberland Gastroenterology will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with Kentucky statute, I will pay the fee for such records. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____
Signature of Patient or legal guardian Date

HIPAA Notice of Privacy Practices

Cumberland Gastroenterology, P.S.C.

606-677-2913

Please read and keep for your records

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

Your protected health information will be used to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. For, example, your information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations may include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight, Directors, and Organ donation, Research, Criminal Activity, Military Activity and National Security: Workers; Compensation: Inmates: Required Uses and Disclosures: Under law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

GASTROINTESTINAL ENDOSCOPY PROCEDURE(S) PERMIT

Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. The following information is presented to help you understand the reasons for, and possible risks of, these procedures.

At the time of your examination, the inside lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed for microscopic study. Small growths can frequently be completely removed (polypectomy). Occasionally during the examination a narrowed portion (stricture) will be stretched to a more normal size (dilation).

THE FOLLOWING ARE THE PRINCIPLE RISKS OF THE PROCEDURES:

1. **Injury to the lining of the digestive tract by the instrument which may result in perforation of the wall and leakage into the body cavities. If this occurs, surgical operation to close the leak and drain the region is often necessary.**
2. **Bleeding. If this occurs, usually is a complication of biopsy, polypectomy, or dilation; management of this complication consists only in careful observation or may require blood transfusion or possibly surgical operation to control.**

Other risks include drug reactions and complications incident to IV and sedation. A brief description of each endoscopic procedure follows: (The number of your planned procedure is circled.)

1. **ESOPHAGOGASTRODUODENOSCOPY: Examination of the esophagus, stomach and a portion of the small intestine, just beyond the stomach. Biopsy, specimen collection, and dilation of strictures may be necessary.**
2. **PROCTOSCOPY OR SIGMOIDOSCOPY: Examination of the anus, rectum, and lower colon (large intestine). Biopsy, specimen collection and dilation of strictures may be necessary.**
3. **COLONOSCOPY: Examination of all or a portion of the colon requiring careful preparation with diet, laxatives, medications, and occasionally enemas. Biopsy, specimen collection and dilation of strictures may be necessary. A polypectomy may be performed using a wire loop and electric current to remove small growths from the colon.**

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures. I am aware of additional cost related to the procedure, i.e. anesthesia, facility and pathology fees if biopsies and/or lesions are removed. Dr. Cook/Dr. Horn/Dr. Bryson prefer the Gastroenterology specific services of GALA and United Pathology Group which will initially be processed under my out of network benefits. I am aware Dr. Cook/Dr. Horn/Dr. Bryson have ownership interest in Lake Cumberland Surgery Center, GALA and United Pathology, as many other physicians do. I am aware I may discuss this with my Physician prior to my procedure and there are other options available to me.

I hereby authorize and permit Dr. Samir Cook/Dr. Todd Horn/Dr. Ben Bryson to perform upon me the following procedures listed above. If any unforeseen condition arises during this procedure calling for additional procedures, operations, or medication (including anesthesia and/or blood transfusion), I further request and authorize him to do whatever he deems advisable in my interest.

I certify that I have read/have read to me the above information regarding my planned endoscopic procedure, and that I have been fully informed of the risks and possible complications thereof. I consent to taking and reproduction of any photographs in the course of this procedure for professional purposes.

_____ _____

Patient or person legally authorized to consent for patient **Date**