5826 Fayetteville Rd
Suite 201
Durham, NC 27713
Phone: 919.246.5611 | Fax: 919.914.0942

PATIENT INFORMATION

DATE: _____

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME: _____

PRIMARY PHONE: _____ ❑ home ❑ cell ❑ work

ALTERNATE PHONE: _____ ❑ home ❑ cell ❑ work

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

SEX: _____❑ MALE ❑ FEMALE DATE OF BIRTH: _____

EMAIL ADDRESS: _____

What GI Symptoms are you experiencing today? Check all that apply:

❑ Atypical Chest Pain	❑Ulcerative Colitis	❑Fecal Incontinence
❑ Functional Dyspepsia	❑Pelvic Pain	❑GI Malignancies
❑ Reflux	❑ Chronic Abdominal Pain	❑ Currently on narcotic medication
❑ Swallowing Disorder	❑ IBS-Diarrhea	Other Functional GI Disorders
❑ Cyclic Vomiting	❑ IBS- Constipation	Other: _____
❑ Vomiting	❑ IBS- Mixed	_____
❑ Nausea	❑ Chronic Constipation	_____
❑ Crohn's Disease	❑ Chronic Diarrhea	_____
❑ IBD	❑ Pelvic Floor Dysfunction	_____

SPECIFIC QUESTION(S) TO BE ADDRESSED_____

_____

_____

_____

Please mark any other conditions you have had or currently experience:

Please mark "P" for Past and "C" for current:	Condition:	Please mark "P" for Past and "C" for current:	Condition:
	Allergies		Hernia
	Aneurysm		High BP
	Angina		High cholesterol
	Arthritis		Joint injuries
	Asthma		Kidney disease
	Cancer		Obesity
	Depression/anxiety		Osteoporosis
	Diabetes		Pacemaker
	Disc problems		Phlebitis (clots)
	Emphysema		Seizures
	Fractures		Stroke
	Heart surgery		Ulcer
	Hepatitis		Varicose veins

Family History: Place a check under applicable family members

Condition:	**Parent**	**Grandparent**	**Sibling**	**Children**
Alzheimer's				
Cancer (type.)				
Diabetes				
Heart attack (age?)				
High blood pressure				

Please list all medications below, including supplements:

Medication:	**Dose:**	**Medication:**	**Dose:**
1		9	
2		10	
3		11	
4		12	
5		13	
6		14	
7		15	
8		16	

Are the following up to date? Please give date of your last:

Pap smear: _____ Normal or abnormal?

Mammogram: _____ Normal or abnormal?

Bone density: _____ Normal or abnormal?

Colonoscopy: _____ Normal or abnormal?

What do you do for exercise? _____

Please list any medication/food allergies: _____

Do you smoke? _____ # Packs per day _____ If former smoker, date quit: _____

Do you drink alcohol? _____ If yes, how much and how often: _____

Anything else you would like the physician to know for your appointment today?

_____

_____

_____

_____

_____

_____

_____

If this is your first visit with Dr Drossman, please let us know how you heard about our practice.

_____

_____

_____

_____

_____

Please be aware that Dr. Drossman periodically hosts professional visitors who choose to spend time with him in clinic in order to improve their clinical skills. Usually they will only observe the clinical visit. When a health professional is visiting the center, you will be asked just prior to seeing Dr. Drossman if you would agree to have this person be present during the visit. While we would appreciate you allowing them to enhance their learning experience with you, you are not obligated to agree to this. Your decision will not affect the core you receive from Dr. Drossman and his team.

Drossman Gastroenterology, PLLC
Financial Policy

As a result of our sincere desire to base all medical decisions on what is best for our patients, not what is best for the insurance company, we are not contracted with any insurance carriers.

1. Drossman Gastroenterology charges $600.00 per hour broken into 5-minute increments for visits or phone consultations. We charge a minimum of $150.00 for phone consultations.

2. All charges must be paid at the time of service and our fee is the same for all patients, regardless of whether they have insurance coverage.

3. Depending on the type of policy, your insurance company may pay for a portion of your medical care. That would be between you and your insurance company. You will be given a completed form (and a duplicate copy for your records) with all the codes necessary for you to file a claim with your insurance carrier. We recommend you contact your insurance carrier and request instructions for filing your claims.

4. It is your responsibility to obtain all referrals/authorizations required by your insurance plan and to file your claim with your referral/authorization.

5. Our office does not fill out "forms" from insurance companies. A copy of the patient's medical records will be forwarded to the insurance company when a signed authorization to release medical records is received. Their medical review professionals can extract the information required from these records.

6. Medicare: Dr. Drossman has chosen to "Opt Out" of Medicare. All patients who are on Medicare or are eligible for Medicare must sign the federally mandated "Private Contract" in order to receive services at our clinic. All services must be paid at the time of service. Neither Dr. Drossman nor the patient may file a claim to Medicare for reimbursement.

7. We will not file any claims for insurance benefits/reimbursement and we will not provide any discounts/write-offs for insurance or workers compensation plans.

8. In the event that you have to cancel your appointment, we require 24 hours' notice. If you cancel less than 24 hours in advance of your scheduled appointment or cancel 2 or more appointments, you will be charged a $75 cancellation fee.

By signing this document, you are agreeing to pay for our services in full on the date of service.
I have read, understand and agree to the terms and conditions listed above.

_____ _____

Signature of Patient or Parent if Patient is a Minor **Date**

5826 Fayetteville Rd
Suite 201
Durham, NC 27713

Medical Information Release Form

Patient:	Date of Birth:	Patient Phone Number

I _____, the patient/guardian/healthcare power of attorney,
authorize Drossman Gastroenterology to (check which applies)

_____ **receive** medical and other information from:

_____ **release** medical and other information to:

Individual Name or Practice (required):

_____

Phone (required): _____ Fax: _____

Specify Email or Street Address*: _____

City (required): _____ State: _____ Zip Code: _____

***There is a charge for printed records.** *If records are being requested to be sent to a lawyer, insurance or workers compensation company, please have them contact us with a written request; otherwise the patient will be charged per North Carolina General Statues 90-411: printed Records Medical Record charges inclusive of searching, handling, copying, and mailing costs are: $.75/page for first 25 pages $.50/page for pages 26-100 $.25/page for pages over 100 Minimum fee of $10.00 permitted*

TREATMENT DATES TO BE DISCLOSED: ❑Entire ❑Year to Date ❑Other _____
PURPOSE OF THE DISCLOSURE: ❑Insurance ❑Legal ❑Continuing Care ❑Personal ❑0ther (specify)
_____
SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:

❑History and Physicals	❑Progress Notes	❑Hospital	❑Correspondence
❑Labs and X-rays	❑Insurance	❑Miscellaneous	❑AII

SPECIFIC INFORMATION TO NOT BE DISCLOSED: _____

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that one the above Information Is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to Drossman Gastroenterology. 1 understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. 1 understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature. I hereby authorize Drossman Gastroenterology to disclose/release medical records and other information obtained In the course of my diagnosis and/or treatment 1 agree to pay copy charges if applicable. I hereby release Drossman Gastroenterology from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 90 days from the date signed. This information may Include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information.

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN DATE

_____ _____
WITNESS DATE

Private Contract

This agreement is between Douglas A Drossman M.D., whose principal place of business is Drossman Gastroenterology at 5826 Fayetteville Rd, Suite 201, Durham, NC, 27713 and

Beneficiary: _____
Who resides at: _____
_____
Medicare ID #: _____

And is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on May 1, 2012 for a period of at least two years, renewed in February 2017 and continued indefinitely. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial
____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's chare for all services furnished by the physician.

____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have opted out.

____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to the beneficiary or his/her legal representative.

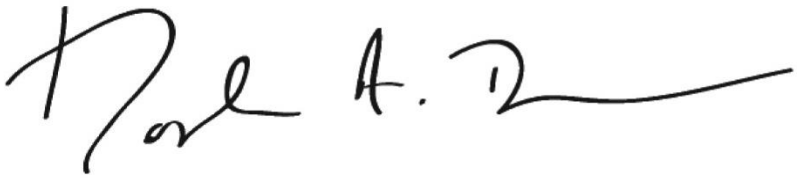
Executed on:

_____
Date

By:

_____
Beneficiary or his/her legal representative

And:



_____
Douglas A. Drossman, M.D.

Notice of Privacy Practices

Effective as of April 17, 2007 (revised September 23, 2013)

NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Grace Physical Therapy and Drossman Gastroenterology maintain a file for each of its patients, The Center and its Providers (collectively the "Center") are part of an organized health care arrangement 'and will share information with each other as necessary to carry out treatment, payment or health care operations related to the Center. Your Medical Records consists of all the information contained in your file.

OUR OBLIGATION TO YOU

We are required by law to maintain the privacy of your Medical Record as described below. Our obligation extends to using or disclosing information in your Medical Record that identifies, or could be used to identify you. Our legal obligations do not apply to uses and disclosures of that information if there is no reasonable basis to believe that the information could be used to identify you. We are required to provide you with this notice explaining exactly what our legal duties are and what practices we follow to ensure compliance with those legal duties.

We may change our Notice at any time. Any changes will apply to all of your Medical Record. Upon your request, we will provide you with any revised Notice by posting the new Notice in our office, making copies of the New notice available in our office or by mail and posting the revised Notice on our website — ww.v.chapelhilldoctors.com.

HOW WE MAY USE AND DISCLOSE INFORMATION IN YOUR MEDICAL RECORD

Although in many instances we are required to obtain your written authorization prior to using or disclosing information in your Medical Record, there are a number of situations in which we may use or disclose that information without your authorization. Those situations are briefly described in this section. Other than under the circumstances described below, we will disclose information in your Medical Records only with your written authorization. Even if you have given us your authorization, you are free to revoke it in writing at any time.

a. **Miscellaneous health-related activities—**we may, without your authorization, use information in your Medical Record to send you appointment reminders, Center newsletters and other health related benefits and services that we believe may be of interest to you.

b**. Use or disclosure for the purpose of treating you—**we may, without your authorization, use information in your Medical Record to make decisions about how to best treat you. We may also disclose information in your Medical record, without your authorization to another Provider who is participating in your treatment for the same reason. This information may be transmitted electronically. For example, a medical assistant may use information in your MR (medical record) to make certain you are given prescribed medications or we may disclose information in you MR to a physician we have referred you for specialized treatment.

c. **Use or disclosure to obtain payment for your treatment—**we may use or disclose MR information in order to obtain reimbursement for treatment we have provided. When your treatment is wholly or partially covered by insurance, the insurance co. will require us to disclose the type of treatment we provided in order that they can determine the amount of reimbursement to which a practice is entitled.

d. **Use or disclosure for our normal business operations—**we may use or disclose information in your MR in the course of our normal health care operations. For example, your information might be disclosed to a third party and used in a peer review analysis of our physicians, or in the training of medical or administrative staff.

e**. Disclosure to certain individuals and disaster relief agencies-** we may without your authorization disclose information in your MR to a member of your family, other relative, close personal friend or any other person you identify to the extent the information directly relates to that person's involvement with your current care or payment for that care. Similarly, we may use or disclose information in your MR to notify or to assist us in notifying a member of your family or another person responsible for your care of your location, general condition or in the unfortunate event of your death. Finally, we may disclose information in your MR to an entity authorized by law or charter to assist in disaster relief efforts, for the purpose of enabling the agency to notify individuals responsible for your care.

f. Disclosure to Business Associates — we may disclose MR information through the use of contracted entities called "business associates". We will always release only the minimum amount of personal information necessary so that the business associate can perform the identified services. we require business associates to appropriately safeguard your information.

USES AND DISCLOSURES REQUIRED BY LAW

We may, without your authorization, use or disclose information in your MR to the extent that the use or disclosure is required by law. For example, we may disclose such information if ordered to do so by a court.

a. Disclosures for public health activities—we may without your authorization disclose information in your MR to a public health or government authority, or person who:

i. Is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability (or to an official of a foreign government agency that is acting in collaboration with, and at the direction of, such a public health authority). For example, we might disclose information in your MR to the Center for Disease Control and Prevention in order to assist with their efforts to limit the spread of infectious disease;

ii. Is authorized by law to receive report of child abuse or neglect;

iii. In accordance with regulations published by the Food and Drug Administration (FDA), is responsible for an FDA-regulated product or activity, provided that the information we disclose is related to the quality, safety or effectiveness of such product or activity; iv. May have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the disclosure is necessary to the conduct of a public health intervention or investigation, but only to the extent that we have been authorized by law to do so;

v. Is your employer (in which case we will give you notice of the disclosure) if we have been retained by the employer to provide health care to you and:

- The purpose of the disclosure is either: to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness /injury;
- The information disclosed consists of findings about a work-related illness or injury or a workplace-related medical surveillance;
- The employer needs the information disclosed in order to comply with its obligations under the Occupation Safety and Health Act or the federal Mine Safety and Health Act to record such illness or injury or to carry out responsibilities for workplace medical surveillance.

b. Disclosures about adult victims or abuse, neglect or domestic violence-If you are an adult, we may without your authorization disclose information from your MR to a government authority authorized by law to receive reports about the abuse, neglect, or domestic violence to the extent the disclosure is required by law and the information disclosed is limited to that required. If we make such a disclosure, we will inform you of the disclosure unless, in our professional opinion, doing so would place you at risk for serious physical or emotional harm.

c. Uses and disclosures for health oversight agencies—we may without your authorization disclose information from your MR to a health oversight agency authorized to conduct audits and investigations related to the integrity of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws affecting the delivery of health care.

d. Disclosures for law enforcement purposes—we may with your authorization disclose information from your MR to a law enforcement official:

i. when disclosure is required by law; when disclosure is required by legal process, such as a court or administrative order or subpoena; in order to identify or locate a suspect, fugitive, material witness, or missing person;

ii. if you have been the victim of a crime are unable to agree to disclosure because of an emergency situation or you are incapacitated, if: in our professional opinion, disclosure is in your best interest, and the law enforcement official states that the information is needed to determine whether someone other than you has violated the law; the information requested is not intended to be used against you; and law enforcement activity would be materially and adversely affected by waiting until you agree;

iii. If we suspect your death resulted from a criminal act; or

iv. If the information is evidence of a crime that occurred on our premises.

e. Disclosures concerning reporting crime in emergencies—if we are providing health care to you in response to a medical emergency we may without your authorization disclose information in your MR to a law enforcement official if the disclosure appears necessary to alert law enforcement officials to: the commission of a crime and the nature of that crime; the location of the crime or of the victim(s) of the crime; and the identity, description, and location of the perpetrator or such crime.

f. Disclosures for judicial and administrative proceedings—we may without your authorization disclose information in your MR to persons other than law enforcement officials if we are ordered to do so by a court or administrative tribunal. In certain circumstances, we may without your authorization also disclose information in your MR to parties for legal proceedings pursuant to a subpoena or other lawful process, even though such disclosure is not ordered by the court or administrative tribunal. Such disclosures may not be made unless the party seeking the information has notified you of that fact or has given us satisfactory assurances that the information provided will not be further disclosed except for the purposes of the litigation.

g. Uses and disclosures related to decedents—at the time of your death we may disclose information in your MR to a coroner or medical examiner for purposes of identification, determination or cause of death, or enabling those officials to perform other duties imposed on them by law.

h. Uses and disclosures for research purposes—generally, we will require your written authorization before disclosing information in your MR for research purposes. However, if researchers have obtained in a manner expressly approved by federal regulation a waiver of the need for an authorization, we may disclose that information without your authorization. We may also disclose it to persons who are in the process of preparing protocols to conduct a research project so long as the information does not leave our premises and the information disclosed is necessary for research purposes. Finally, upon verification

of your death we may disclose information in your MR to researchers whose research is limited to decedents and who represent that the information for which disclosure is sought is necessary for the research purposes.

i. Uses and disclosures to avert serious threat to health or safety—we may without your authorization disclose information in your MR if we believe that the disclosure is necessary to prevent or abate a serious and imminent threat to the health safety or a person or the public, and the information is disclosed to a person or persons reasonably able to prevent or lessen the threat. We may also disclose information in your MR to enable law enforcement authorities to take you into custody if you have admitted that you took part in a violent crime and we believe that serious physical harm to an individual may have resulted or if it appears to us that you have escaped from a correctional institution or other lawful custody.

Uses and Disclosures for Specialized Government Functions

a. Disclosure for national security and intelligence activities— we may without your authorization disclose information in your MR to federal officials who are engaged in national security or other lawful intelligence activities and to personnel engaged in the protection of the President of the United States and other officials for whom similar protection is provided.

b. Disclosure regarding persons in custody— if you are an inmate in a correctional institution or in other lawful custody we may without your authorization disclose information in your MR to the correctional institution or other lawful custodian If the information is necessary to provide you with health care; to ensure your health and safety, or that of other inmates or person in custody or employees of your custodian.

c. Disclosure for workers' compensation—we may without your authorization disclose information in your MR to the extent that disclosure is authorized and necessary to comply with laws relating to workers' compensation.

The following uses and disclosures of your MR require your written authorization:

a. Marketing
b. Disclosures for any purposes which require the sale of your information
c. Release of psychotherapy notes

Your Individual Rights

You have the following rights with regard to the information in your Medical Record.

Right to request restrictions on use and disclosure of information in your MR—although as noted above our right to use and disclose information in your MR is restricted by law in many circumstances you have the right to request other restrictions on how we use the information in your MR. You may also request that we restrict to whom we will disclose that information. We are not required to agree to any restriction you may request and we are not allowed to agree to any restriction that is not permitted by law. There is one restriction; we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

Right to request confidential communications of protected health information—you have a right to request that we communicate with you about information in your MR in a manner that differs from the manner we would normally employ or at a location other than that to which we normally address such communications. For example, you might request that with respect to particular health care services you receive we communicate with you only in writing and that any such communication be sent to a location other than your home address. We will try to accommodate all reasonable requests.

Right to inspect and copy health information—except for certain specified information (including psychotherapy notes and information prepared in anticipation of, or for use in, a judicial proceeding) you have a right to access the information in your MR to inspect it and if you wish, copy it. The information you have a right to inspect and copy includes both health-related and payment information.

Right to amend information contained in your MR—you have a right to request that we amend information contained in your MR. We may deny your request for a variety of reasons including our determination that the information contained in your MR is complete and accurate.

Right to an accounting of disclosures of information iii your MR—you have a right to receive an accounting of most disclosures that we may make of information in your MR. Some disclosures that we may make, such as those disclosures permitted by law, are exempted from your right to an accounting.

Additional Privacy Rights

a. You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
b. You have a right to receive notification of any breach of your Medical Record.

Complaint Procedures

You have a right to file a complaint with us or with the Office of Civil Rights of the U.S. Department of Health and Human Services if you believe your rights to medical record privacy have been violated. To file a complaint with us write to:

HIPAA Contact Person
5826 Fayetteville Rd
Suite 201
Durham, NC 27713

In your complaint, be sure to specify which of our polices or procedures you believe have not been followed or how else you believe we have not provided you with the privacy to which you are entitled under the law. We pledge to respond to all complaints that are filed. you will not be penalized for filing a complaint.

Acknowledgement of Receipt of the Center Notice of Privacy Practices

I acknowledge that I have received a copy of the Center's Notice of Privacy Practices.

_____

Name of Patient/Personal Representative (Please print)

_____ _____

Signature of Patient/Personal Representative Date