



ATLANTA COLON & RECTAL SURGERY, P.A.

Today's date: _____

Patient Name: _____

Birth Date: _____

Race: _____

Marital Status: Single

Married

Widowed

Divorced

Employer: _____

Spouse's Name: _____

Current Medications & Dosage

(If you do not know the drug name, list the condition)

Please list all your DRUG ALLERGIES: _____

Social History

Do you smoke? _____

Frequency _____

Do you consume alcohol? _____

Frequency _____

Do you take drugs? _____

Frequency _____

Past Medical History

Have you ever experienced any of the following conditions? (Please check all that apply.)

Anemia

Crohn's Disease

Mitral Valve Prolapse

Asthma

Diabetes

Pneumonia

Bladder Infection

Heart Disease

Stroke

DVT

Hepatitis

Thyroid Disease

Pulmonary Embolism

High/Low Blood Pressure

Urinary / Prostate

Cancer

HIV +

Other History:

Colitis

Kidney Disease

Past Surgical History

Have you ever had a colonoscopy? Yes No

If yes, when _____ and results _____

Family Medical History

	Relative	Condition & Age	None
Family History of Cancer			
Family History of Colon Polyps/Tumors			
Family History of Colon Disease			

Patient Name: _____

Date of Birth: _____

Present Medical Complaints

Reason for your visit:

Please indicate either a yes or no response next to each item. Please do not leave blanks. For physician review purposes, any type of mark (e.g. line, X, check, etc.) will indicate a negative or positive response and not a deferment.

Review of Systems		No	Yes		No	Yes		No	Yes	
Constitutional				Cardiovascular				Neurological		
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>		Chest pain	<input type="checkbox"/>	<input type="checkbox"/>		Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath w/walking	<input type="checkbox"/>	<input type="checkbox"/>		Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Light headed/dizzy	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/Weakness	<input type="checkbox"/>	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		Convulsion or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal				Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>		Numbness or tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>		Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>		Respiratory				Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		Chronic coughing	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>		Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>		Psychiatric		
Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding with bowel movements	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Pain	<input type="checkbox"/>	<input type="checkbox"/>		Musculoskeletal				Ear/Nose/Mouth/Throat		
Rectal Swelling	<input type="checkbox"/>	<input type="checkbox"/>		Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>		Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Protrusion from rectum	<input type="checkbox"/>	<input type="checkbox"/>		Joint stiffness/swelling	<input type="checkbox"/>	<input type="checkbox"/>		Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>		Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>		Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>		Back pain	<input type="checkbox"/>	<input type="checkbox"/>		Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>		Difficulty in Walking	<input type="checkbox"/>	<input type="checkbox"/>		Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		Integumentary (skin/breast)				Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary				Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>		Hematologic/Lymphatic		
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>		Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding or bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>
Burning/Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>		Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>		Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>		Past transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence of urine	<input type="checkbox"/>	<input type="checkbox"/>		Breast lump	<input type="checkbox"/>	<input type="checkbox"/>		Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>		Eyes				HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>		Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>		Endocrine		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>		Hormone problem	<input type="checkbox"/>	<input type="checkbox"/>
Sexual difficulty	<input type="checkbox"/>	<input type="checkbox"/>		Eye disease/injury	<input type="checkbox"/>	<input type="checkbox"/>		Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>
Male-Testicle Pain	<input type="checkbox"/>	<input type="checkbox"/>		Female-# of pregnancies _____				Hyper/Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Female-Stool through vagina <input type="checkbox"/> <input type="checkbox"/>				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Female-vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>						Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

How often do you move your bowels? _____ per day _____ per week

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ **Date:** _____

Physician Statement: I have reviewed the questionnaire with the patient.

Signed: _____ **Date:** _____

ATLANTA COLON AND RECTAL SURGERY, P.A.
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of **ATLANTA COLON AND RECTAL SURGERY, PA's** Notice of Privacy Practices.

I consent to the use and disclosure of my protected health information by Atlanta Colon and Rectal Surgery, PA for the purpose of providing treatment to me, obtaining payment for my health care bills, and/or to conduct health care operations.

I understand I have a right to review Atlanta Colon and Rectal Surgery, PA's Notice of Privacy Practices prior to signing this document. Atlanta Colon and Rectal Surgery, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the practice website, calling the office and/or requesting a revised copy by sent in the mail.

I understand that I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Atlanta Colon and Rectal Surgery, PA is not required to agree to the restrictions that I may request. However, if Atlanta Colon and Rectal Surgery, PA agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Atlanta Colon and Rectal Surgery, PA has taken action in reliance on this consent.

Signature of Patient or Personal Representative

Date

ASSIGNMENT OF BENEFITS

Assignment of Insurance Benefits: I hereby authorize payment directly to Atlanta Colon and Rectal Surgery, PA, of any and all insurance benefits for this visit, hospital inpatient and outpatient stay, otherwise payable to or on behalf of the patient or to me, and authorize release of information requested by the patient's insurance company (ies).

Signature: _____ Date: _____
(Patient or authorized representative)

Assignment of Medicare and/or Medicaid Benefits: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or Georgia Medical Care Foundation or its intermediaries or carriers any information needed for this or a related Medicare and/or Medicaid Claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare and/or Medicaid for payment to me.

Signature: _____ Date: _____
(Patient or authorized representative)

Office Use Only:	
Refusal to Sign:	
1. _____	_____
Employee Signature	Date
2. _____	_____
Employee Signature	Date

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to the treating physician, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions: You may request a restriction on our use and disclosure of PHI (except in emergencies), but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where "the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full. Please contact our office if you want to further restrict access to your health care information. This request must be submitted in writing.

Request Confidential Communications: You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with practice administration or directly to the Secretary of Health and Human Services.

To file a complaint with our administration, you must make it in writing within 180 days of the

suspected violation. Provide as much detail as you can about the suspected violation and send it to Atlanta Colon and Rectal Surgery, PA, 5667 Peachtree Dunwoody Road, Suite 330, Atlanta, Georgia 30342. You should know that there would be no retaliation for your filing a complaint.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and/or business operations. When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available. To request this list or accounting of disclosures, you must submit your request in writing. Lists, if requested, will be charged for each page and the staff time required to locate and copy your health information. Please contact our staff for a fee and/or for an explanation of our fee structure. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

We reserve the right to revise or amend this Notice of Privacy Practices. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

If you have any questions regarding this notice, please contact in writing:

**Attn: HIPAA Privacy Officer
Atlanta Colon and Rectal Surgery, PA
5667 Peachtree Dunwoody Road, Suite 330
Atlanta, Georgia 30342**

Original Effective Date: 4/01/2003, Amendment Date: 05/01/2010

Atlanta Colon and Rectal Surgery, PA



NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

Ways in Which We May Use and Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We have established "minimum necessary" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example, we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances. We also may use and disclose your protected health information to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your protected health information to bill you directly for services and items. We may disclose your protected health information to other health care providers and entities to assist in our collection efforts. For example, we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Healthcare Operations: We will use and disclose your protected health information to support the business activities of our practice. For example, we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Other Ways We May Use and Disclose Your Protected Health Information

Treatment Alternatives: We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care: We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law: We may use and disclose your protected health information when we are required to do so by law: (Court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement. You will be notified of any such disclosures.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counter intelligence or other national security activities, we may disclose it to authorized federal officials.

Worker's Compensation: We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates: We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Healthcare Reminders: We may use or disclose your health information to provide you with healthcare reminders, including, but not limited to, voicemail messages, postcards or letters.

Your Privacy Rights as our Patient

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) Any psycho-therapy notes that may have been included in records we received about you are not available for your inspection or copying by law. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our staff for a copy of the Request Form. You may also request access by sending us a letter to the address below. Once approved, an appointment can be made to review your records. Copies, if requested, will be charged for each page and including the time required locating and copying your health information. If you want the copies mailed to you, postage will also be charged.

If you wish to inspect or copy your medical information, you must submit your request in writing to Atlanta Colon and Rectal Surgery, PA, 5667 Peachtree Dunwoody Road, Suite 330, Atlanta, Georgia 30342. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.