PATIENT INFORMATION

Thank you for choosing our office. Please print. All information will be confidential.

Patient Name______________________ Birthdate______________ ☐ Male ☐ Female
SSN______________ Home Phone______________ Cell Phone______________
Address______________________ City______________ State________ Zip________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Race: Black, White, Asian, Other Ethnicity: Hispanic, Not Hispanic Email______________
Preferred Pharmacy Name and Location______________________
Patient's or parent's employer______________________ Work Phone______________
Whom may we thank for referring you?______________ PCP Name______________
Person to contact in case of emergency______________ Phone number______________
Is there a private line that you prefer for our office to use to leave a message and/or results? ☐ Yes ☐ No
If yes, please list the number that you prefer for us to use______________________
In the space given below, list the names of any individuals and their relationship to you, that you wish to have access to your medical information ______________________

Please tell us if you wish to receive information from our office by either Text Message, Voice Message, or email. ______________________

Insurance Information

Name of Insured______________________ Relation to patient______________
Address______________________ City______________ State________ Zip________
Birthdate______________ SSN______________ Name of Employer______________
Insurance Co. Name______________________
ID/Policy Number______________________ Group Number______________

Secondary Insurance Information

Name of Insured______________________ Relation to patient______________
Address______________________ City______________ State________ Zip________
Birthdate______________ SSN______________ Name of Employer______________
Insurance Co. Name______________________
ID/Policy Number______________________ Group Number______________

Responsible party if the patient is a minor, ward of the state, or power of attorney

Name of person responsible for the account______________Relationship to patient______________
Address______________________ City______________ State________ Zip________
Birthdate______________Driver's License State________Driver's License Number______________
Home Phone______________________ Work Phone______________________

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits other wise payable to me directly to the doctor. I understand that I am financially responsible for any balance not covered by my insurance or if I supply false or incorrect insurance information.

X______________________ ______________________
Signature of patient, parent of minor or POA Date

Mid-State Gastroenterology, PLLC
1115 B. Dow Street, Murfreesboro, TN 37130 615-896-6996

HIPAA NOTICE OF PRIVACY PRACTICES

Mid-State Gastroenterology, PLLC
All providers

1115 B. Dow Street
Mufreesboro, TN 37130
615-896-6996

741 President Place, Suite 230
Smyrna, TN 37167
615-220-5780

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.

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 purposed 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 my identify you and that relates to your past, present or future physical or mental health or 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: We will use and disclose your protected health information 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 PHI as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to who 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 need, to obtain payment for your health care services. For example, obtaining approval for a 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 disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet a 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 include: as Required By Law, Public Health issues as required by law, Communicable diseases: Health Oversight: Abuse or Neglect: Food & Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the 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 our physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information; Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, our use in a civil, criminal, or administrative action or providing, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for the notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to received confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal at your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy of your complaint. We will not retaliate against you for a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office of 615-896-6996.

Mid-State Gastroenterology, PLLC

1115 B. Dow Street, Murfreesboro, TN 37130

Patient Agreement

Limitation of Practice: Patient understands that Dr. Sarvaria's practice is limited to gastroenterology.

Privacy Policy

All patients have a right to review our Notice of Privacy Practices, which is attached for your review. If you would like to restrict access or request modifications be made to your Personal Health Information, please request the required form from a member of our staff.

Procedure Policy

Patient hereby understands that if a colonoscopy/EGD has been scheduled on the patient's behalf, due to the significant amount of paperwork involved, we ask that the patient please contact our office at least 72 hours prior at 615-896-6996 should a cancellation or reschedule need to occur.

Please Note: Insurance benefits may vary and pay differently for SCREENING (no symptoms) than DIAGNOSTIC (i.e. bleeding, constipation, diarrhea, pain). Please keep in mind that a procedure may change to diagnostic classification if a polyp is removed and /or a biopsy performed for any other finding.

Patient Financial Policy

Our Policy requires payment at the time of service for your visit. We accept cash, credit card and personal checks with proper identification. (A $35.00 overdraft charge will be added to all returned checks and accounts turned over to our collection agency).

If u are a member of an HMO or PPO or any Tenncare plan, who has chosen us as a provider of your care.

It is your responsibility to: provide us with information relative to your claim, including insurance card, number, employer, date of birth, address, social security number. This information is requested on the Patient Information registry sheet, which we ask you to complete during your initial or subsequent visit.

Pay your deductible or co-payment at the time of service, and pay for any service not covered by your insurance carrier.

Make sure we have a current referral if our insurance requires one. You may be sent back to see your primary care physician prior to treatment in order to obtain a current referral. If we do not have this referral at the time of visit, your insurance company may hold you responsible for all charges.

It is our responsibility to: submit your claim to your insurance carrier. Provide your insurance carrier with information necessary to determine the medical and/or surgical need of the care you received.

If we are out-of-network with your insurance company, we will require that you pay for your visit at the time of service, assist you in submitting your claim by providing your with a detailed statement of charges, which your may forward to your insurance company.

When your bill (outstanding balance) is not paid after 90 days of the first statement, a collection agency will be chosen to manage your delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs of the collections including; court costs, legal fees and collection agency fees.

Consent to Access Prescription History: Our providers use an electronic medical record that allows them to electronically send prescriptions directly to pharmacies. Our system also allows our providers to access a list of prescriptions filled by you within the last 2 years. Reviewing this list helps to assure patient safety and avoid duplication of medications and/or drug interactions. By signing below you give your permission to access your prescription history from an external source. If you do not wish to give us permission, please let our staff know so that we can have you write NO on this section prior to signing.

I have read and fully understand my responsibilities under these policies.

______________________________ __________________

Patient signature Date