Digestive Health Associates of Northern Michigan, P.C.

Acknowledgement of Receipt
Notice of Privacy Practices

I understand Digestive Health Associates of Northern Michigan, P.C.'s notice of privacy practices are available upon request and are also posted on the bulletin board in the waiting room of their office.

_____ _____

Patient Signature Date

_____

Print Name

_____

Date of Birth

Digestive Health Associates of Northern Michigan, P.C.

PATIENT INFORMATION FORM

DATE / /

LAST	FIRST	MIDDLE	NICKNAME

PERMANENT ADDRESS	CITY	STATE	ZIP
SECONDARY/MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	E-MAIL ADDRESS
( )	( )	( )	

SOCIAL SECURITY #	BIRTHDATE	GENDER	MARITAL STAUS	EMPLOYER
– –	/ /	☐M ☐F	S – M – W – D	

ETHNICITY	RACE	PREFERRED LANGUAGE
☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO	☐ AFRICAN AMERICAN ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐CAUCASIAN ☐NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐MULTIRACIAL ☐ OTHER	☐ ENGLISH ☐ OTHER _____

SPOUSE	SPOUSE SOCIAL SECURITY #	SPOUSE BIRTHDATE	SPOUSE EMPLOYER
	– –	/ /	

GUARDIAN	GUARDIAN RELATIONSHIP	GUARDIAN BIRTHDATE	GUARDIAN PHONE
		/ /	

EMERGENCY CONTACT	EMERGENCY CONTACT RELATIONSHIP	EMERGENCY CONTACT PHONE #

REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

AUTHORIZATION TO RELEASE INFORMATION

I, _____ authorize Digestive Health Associates of Northern Michigan, P.C. (Drs. Antinozzi, Barnes, Galan, Goldman, Hegewald, Henbest, Sanford, Sue Coffin, PA-C, Kathy Holmstrom-Baker, PA-C, and Sarah Flickinger, PA-C) to release and/or discuss information relevant to my care to the following individuals:

_____Spouse (Name) _____

_____Other (Name and Relationship) _____

I also authorize information about my health care, including appointments, test results or other messages, to be left on my answering machine, in the event that I am not available.

_____ Yes _____No

I request payment of authorized Medicare or other insurance benefits to be made to either myself or on my behalf to Digestive Health Associates of Northern Michigan for any services rendered to me. I authorize release of medical information about me to the Health Care Financing Administration (Medicare) and/or my insurance carrier. This information is to be used for the purpose of evaluating and administrating benefits.

_____Medicare
_____Other Insurance (Name of Company)_____

I understand that I am financially responsible for any amount not covered by my insurance contract. I accept responsibility for obtaining necessary referral forms.

This release will be considered valid from the date indicated below and will remain in effect until such time as I withdraw it in writing.

_____ _____
Signature of Patient Date

_____
Witness

HEALTH HISTORY QUESTIONNAIRE

Digestive Health Associates of Northern Michigan, P.C.

Name:_____
Age:_____ DOB:_____ ☐Male ☐Female
Today's Date:_____Reason for Visit:_____
Allergies:_____

PAST HISTORY (✓ all that apply)
☐ Seizure_____
☐ Stroke/TIA_____
☐ Head Injury(when)_____
☐ Congestive Heart Failure_____
☐ Heart Attack (when)_____
☐ High Blood Pressure_____
☐ Bleeding ☐ Clotting Problem
☐ High Cholesterol
☐ Asthma ☐ Emphysema
☐ Hiatal Hernia ☐ Ulcer
☐ Liver Disease ☐ Hepatitis
☐ Ostomies
☐ Kidney Disease ☐ Kidney Stone
☐ Diabetes ☐ Hypoglycemia
☐ Thyroid Problems
☐ Arthritis ☐ Limited Motion
☐ HIV ☐ AIDS
☐ Cancer/Tumor (site)_____
☐ Chemotherapy/ Radiation_____
☐ Depression ☐Alcoholism
☐ Suicide Attempt
☐ Chronic Pain

LIST GASTROINTESTINAL SURGERIES (approximate dates):
(Please use back for additional info)
_____
_____
_____
_____
_____
_____

OTHER SURGERIES:
_____
_____
_____
_____
_____

MEDICINE (Type and Dosage)
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS – (Recently)

Constitutional
☐ Chills ☐ Fever
☐ Uneasiness ☐ Weight loss

HEENT
☐ Double Vision ☐ Ear Infection
☐ Eye Pain ☐ Nasal Congestion
☐ Sinus Infection ☐ Sore Throat

Respiratory
☐ Shortness of Breath
☐ Frequent Cough ☐ Wheezing
☐ Severe Chest Pain

Cardiovascular
☐ Chest Pain ☐ Extreme Edema
☐ Palpitations

Gastrointestinal
☐ Abdominal Pain
☐ Change in bowel habits
☐ Constipation ☐ Diarrhea
☐ Heartburn ☐ Vomiting of Blood
☐ Blood in Stool ☐ Black Stool
☐ Loss of appetite
☐ Nausea ☐ Reflux ☐ Vomiting

Genitourinary
☐ Painful Urination
☐ Blood in Urine
☐ Urinary frequency
☐ Urinary Incontinence
☐ Urinary Retention

Reproductive
☐ Breast lumps ☐ Breast Pain
☐ Vaginal discharge
☐ Penile discharge
☐ Sexual dysfunction

Metabolic/Endocrine
☐ Cold intolerance
☐ Excessive thirst
☐ Heat intolerance
☐ Enlarged Breast in Men

Neurological
☐ Dizziness ☐ Headache
☐ Numbness ☐ Tremors
☐ Vertigo

Psychiatric
☐ Anxiety ☐ Depression
☐ Increased Stress

Integumentary
☐ Contact allergy ☐ Hives
☐ Scratching ☐ Rash

Musculosketal
☐ Back Pain ☐Muscle Pain
☐ Joint Pain

Hematologic/Lymphatic
☐ Easy bleeding
☐ Easy bruising
☐ Swollen Lymph Nodes

Immunologic
☐ Asthma
☐ Chemicals in work place
☐ Food allergies
☐ Immunosuppression
☐ Seasonal allergies

Other Medical Problems
_____
_____
_____
_____
_____

FAMILY HISTORY
(List Family Member and Type)
☐ Heart Disease _____
☐ Cancer _____
☐ Colon Polyps_____
☐ Colon Cancer_____
☐ Diabetes _____
☐ Other _____

SOCIAL HISTORY
Occupation _____
☐ Smoke Cigarettes
Packs per day_____
For How Long_____
Year Quit_____
☐ Drinks caffeine
Cups per day_____
☐ Recreational drugs
☐ Consumes alcohol
Frequency_____
For how long_____
Year quit_____

REVIEWED BY_____DATE_____

Digestive Health Associates of Northern Michigan, P.C.

"No Show" Policy
For Office Visits & Procedures

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide adequate notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancelations made less than 24-48 hours notice, we are unable to offer that appointment slot to other people.

- Patients who fail to show for their scheduled office appointment or do not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show" penalty of $50.00. In the event of an actual emergency and prior notice could not be given, consideration will be given - and an exception may be granted.
- Patients who fail to show for their scheduled procedure appointment or do not notify the office within 48 hours of their scheduled appointment time shall be subject to a "No Show" penalty of $150.

We understand that special unavoidable circumstances may cause you to cancel within this time frame. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand, and agree to this "No Show" Policy.

_____ _____

Patient Signature Date

_____

Print Name

_____

Date of Birth

COMMUNITY REGISTRY DISCLOSURE AND AUTHORIZATION

Patient Information	
Name: _____	Phone Number: _____
Address: _____	E-mail Address: _____
_____	Date of Birth: _____

Digestive Health Associates of Northern Michigan, P.C. participates in a Community Registry operated by Northern Physicians Organization, Inc. (NPO). This Registry is a tool that we and others involved in your care can use to carry out your treatment and engage in activities to help manage your care such as coordinating your care, conducting quality assessment and improvement activities, and related planning and management activities that do not include treatment (*i.e.*, health care operations).

☐ I opt-out of the NPO Community Registry.

- OR -

☐ I understand that by signing this form, I agree to allow the providers involved in my health care to talk to each other about my care, electronically share my health information with each other to give me better care, and to use my information in health care operations. The software system used by NPO meets the privacy and security standards of both the Health Insurance Portability and Accountability Act (HIPAA) and Michigan law.

WHAT MAY BE DISCLOSED: I authorize my Provider to disclose all of my health information, including demographic information, allergies, medications, immunizations, lab reports, problems and diagnosis, mental health conditions, birth control and abortion, alcohol or drug use problems, my care plan, health care providers, sexually transmitted diseases (STDs), HIV/AIDS, and genetic diseases or test results. This includes information created before and after the date of this Authorization.

WHO MAY RECEIVE THE INFORMATION:

(1) I authorize my Provider to disclose my health information to NPO and its participating physicians and physician groups that have entered into a written agreement with NPO, before or after the date of this Authorization; and

(2) I authorize NPO to disclose my health information to **(a)** its participating physicians and physician groups that have entered into a written agreement with NPO, before or after the date of this Authorization; and **(b)** other health care service providers (*e.g.*, labs and hospitals) that have entered into a written agreement with NPO, where they have agreed to comply with HIPAA and Michigan privacy laws.

PURPOSES: I allow disclosure of my health care information for medical treatment, to coordinate care among my providers, and to improve my provider's health care operations.

EXPIRATION: This consent will expire, **(i)** upon my death, **(ii)** when my Provider ceases its relationship with NPO, or **(iii)** NPO ceases operation of the Community Registry, whichever is sooner.

REVOCATION: I can revoke my permission at any time by giving written notice to my provider except to the extent the disclosures I agreed to have already been acted on.

ADDITIONAL RIGHTS: I understand that I have additional rights under HIPAA, including the right to request restrictions on certain uses and disclosures of my health information, the right to inspect and copy my health information, and the right to request amendments to my health information, and that these rights are further explained in my Provider's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Parent/Guardian or Personal Representative Date Authority to Act