ESOPHAGEAL INSTITUTE OF ATLANTA
2045 Peachtree Road NE, Suite 310
Atlanta, GA 30309

Patient Pre-Registration Instructions

Thank you for making an appointment with Esophageal institute of Atlanta. Our goal through the appointment process is to gather information in advance of your appointment so that on the day of your visit you will have a smooth and efficient experience in our office.

To achieve this goal we need you to complete this package of documents. All documents are in a PDF format and can be completed using Adobe Acrobat Reader or any PDF reading software. Adobe Acrobat Reader is a free program that can be downloaded from the following website https://get.adobe.com/reader/.

Please fill in all sections unless the information is not relevant to your situation. Signatures on forms can also be completed electronically. Once you have completed the forms, save them to your computer and return them via email as an attachment.

Alternatively, if you do not have the ability to complete these electronically and return via email attachment, you can print them and fill them out by hand. Plan to bring them with you on the day of your appointment. Please be aware that hand completed forms will require an additional 30 minutes of time on the day of your appointment in order to process all forms. Please come to your appointment 30 minutes early if you will be providing hand written registration and insurance forms.

This packet includes the following forms:

1. New Patient Registration Form
2. Initial Clinical History and Physical Form
3. Financial Policy
4. Privacy Policy
5. Patient HIPPA Acknowledgement and Consent Form

If you have any questions please contact us at:

404-445-7787

Info@esophageal.institute

Esophageal Institute of Atlanta

Patient Registration Form

PATIENT INFORMATION (Please Print)

◯ Dr. ◯ Mr. ◯ Mrs. ◯ Ms.

Patient's Name (Last)_____ (First)_____ (Middle)_____

Social Security Number _____ ◯ Female ◯ Male Date of Birth _____
000 - 00 - 0000 *00 / 00 / 0000*

E-mail Address_____

Primary Phone No. _____ ◯Cell ◯Line Other Phone No. _____ ◯Cell ◯Line

Preferred Method of Contact ◯ Phone ◯ Text ◯ E-Mail

Address1_____ Address2 _____

City _____ State_____ Zip _____

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship _____

Referring Physician Name_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____

Insurance Company_____ Phone Number _____

Subscriber ID (Policy Number) _____ Group ID _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured _____

Insurance Company_____ Phone Number _____

Subscriber ID (Policy Number) _____ Group ID _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Esophageal Institute of Atlanta

Initial Clinical History and Physical Form

Date: _____

Patient Information

Name: _____

Race: ○ Caucasian ○ African American ○ Asian ○ Hispanic ○ Multi-Racial ○ Oher

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed No. Children _____

Reason for Visit: _____

Past Medical History
(Please check all conditions that you have or have had.)

- ☐ None
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Obstructive Sleep Apnea
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Bleeding Difficulties
- ☐ Hepatitis A B or C
- ☐ HIV
- ☐ Chronic Steroid Use
- ☐ Diabetes-Oral Meds
- ☐ Diabetes-On Insulin
- ☐ High Cholesterol
- ☐ Seizure
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Osteoporosis
- ☐ Allergy: Food
- ☐ Allergy: Seasonal
- ☐ TB
- ☐ Hypothyroid
- ☐ Hyperthyroid

Cancer: Type/Treatment: _____

Other (Specify): _____

Past Surgical History (Type of Surgery & Year)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Prescription Medications

Medication	Dose/Number per Day	Medication	Dose/Number per Day
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Esophageal Institute of Atlanta

Initial Clinical History and Physical Form (Page 2)

Patient Name: _____

Drug Allergies

- ☐ No known drug allergies
- ☐ Latex
- ☐ Tape

1. _____
2. _____
3. _____
4. _____

Social History
(Please check the appropriate listings)

Tobacco Use

- ○ Never
- ○ Quit
- ○ Current Smoker

How many years? _____

Alcohol Use

- ○ None
- ○ Socially
- ○ Daily
- ○ Heavy

Exercise

- ○ None
- ○ 1-2x/week
- ○ 3-4x/week
- ○ 5-7x/week

Employment

- ○ Unemployed
- ○ Employed - Manual Labor
- ○ Employed - Office

History of Esophagus or Stomach Conditions
(Please check the appropriate listings)

Care with Gastroenterologist?

- ○ Yes
- ○ No

GI Name: _____

Current Diagnoses

- ☐ GERD
- ☐ Hiatal Hernia
- ☐ Barretts
- ☐ LPR
- ☐ Esophageal Cancer
- ☐ Other:_____

Recent Testing (Last 6 months)

(Please check the appropriate listings)

- ☐ EGD (upper endoscopy)
- ☐ Bravo pH
- ☐ Impedence pH
- ☐ Barium Swallow
- ☐ Upper GI
- ☐ Esophageal Motility
- ☐ Gastric Emptying
- ☐ Restec pH

Previous Surgery

- ☐ Stomach Surgery
- ☐ Esophageal Surgery
- ☐ Weight Loss Surgery

ESOPHAGEAL INSTITUTE OF ATLANTA

Financial Policy

Our staff is concerned with the costs associated with your healthcare and wish to address current issues related to medical services provided in our office setting. Considerable care has been taken in the establishment of our fee schedule and we want to assure you our charges accurately reflect the complexity of care rendered along with the skill and expertise required in providing quality care to you.

Items listed below are not covered by your insurance carrier and will be priced accordingly when the request is received by our office:

- All services will be filed with your insurance carrier with the exception of records request, FMLA or other associated paperwork, cancellation notices and returned check fees. Any medical service(s) not covered by your insurance plan will become your financial responsibility.

- Payment for services is due and payable with each visit. Deductible, co-payments, and co-insurance payments are due and payable at the time of service. If you are unable to provide payment of items deemed your financial responsibility, your appointment will be rescheduled for a later date and time.

- If you have an HMO plan, it is your responsibility to ensure you have the appropriate referral from your primary care physician. If you do not have the appropriate referral and our office must obtain one, a fee of $25.00 will be applied to your account.

- Returned checks will result in a $30.00 fee applied to your account.

- A 24-hour cancellation notice is required for office visits. If you are unable to make your scheduled appointment and do not provide a 24 hour notice to cancel a $30.00 fee will be applied to your account.

- A request for medical records must be made in writing to our office. Upon receiving the request, our office will process the records request within a 72-hour period. The fee for Medical Records is $15.00 and is due and payable at the time of the request.

- Requests for the completion of the medical documents such as Disability leave, Cancer, Life or other health insurance forms, Employment exams, School physicals exams, Family Medical Leave (FMLA) or other documents required by a third party other than your insurance carrier will have a $25.00 fee due at the time of request for said documents. Upon receiving the request our office will process the records request within a 72- hour period.

We encourage you to contact your benefits coordinator through your employer or contact your insurance carrier directly to verify your own benefits, eligibility, and other services that may or may not be covered. Whether you have insurance coverage or not, the party ultimately responsible for services provided by our office, staff and physicians will be you.

1, _____ have read and understand my financial responsibilities as explained in this Financial Policy.

_____ _____

Patient Signature **DATE**

ESOPHAGEAL INSTITUTE OF ATLANTA
PATIENT HIPPA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
☐*I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*
☐ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Esophageal Institute of Atlanta

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

This notice applies to all Piedmont Healthcare Facilities including its hospital, emergency services and outpatient offices and administrative services.

Esophageal Institute of Atlanta
2045 Peachtree Road NE, Suite 2310. Atlanta, GA 30305. Phone: 404-445-7787