SUMNER
PHYSICIAN PRACTICES
HIGHPOINT HEALTH SYSTEM

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic 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 hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic

to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** 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. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

Printed Name of Patient or Representative

Signature of Patient or Representative

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HIGHPOINT HEALTH SYSTEM

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

Witness (Staff) Signature

Witness (Staff) Printed Name

Date: _____

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. We request timely notification to our practice to enable another patient, waiting for an appointment, to be scheduled. Our goal is to provide the highest quality of care and service to you and other patients.

Please review our policy below:

- **Scheduled Procedures**
  - **48 hours notice** is required to be timely
  - **$100 fee** for a "No-Show" or Cancellation without timely notice
- **Office Appointment**
  - **24 hours notice** is required to be timely
  - **$25 fee** for a "No-Show" or Cancellation without timely notice
- Definition of a "No Show": An appointment for which the patient does not attend and has not provided a call to cancel the office appointment or procedure appointment.
- Patients who incur a "No-Show" or untimely Cancellation two (2) or more times in a 12 month period, will be required to obtain a new referral from their Primary Care Physician.
- Insurance does not cover this fee and payment is due at or before the next visit.
- **Patients are responsible for rescheduling the office appointment or procedure.**

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval. Please ensure to reschedule your appointment.

Questions about cancellation and no show fees should be directed to the Billing Department (615-328-5253). Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient Name (Please Print) _____

Signature of Patient or Patient Representative _____

Date of birth _____

Patient Medical History

Date:_____Name:_____D.O.B._____

Primary Care Doctor:_____Doctor's Phone Number_____

Reason For Visit: (Please Circle One) New Patient Established (Follow-Up Care)

Medical History: (Please Circle All That Applies)

Were you born between 1946 and 1964_____ Have you been tested for Hep. C_____

Heart Disease Stroke High Blood Pressure High Cholesterol Diabetes Asthma COPD Seizures

Thyroid Problems Liver Disease Hepatitis C Hepatitis B Acid Reflux Irritable Bowel Back Pain

Fibromyalgia Migraines Anxiety Depression Crohn's Disease Kidney Disease Colon Cancer

Cancer_____(List Type)

Surgical History: (If Applicable, Please list along with year)

Name of Surgery:_____Year:_____

Name of Surgery:_____Year:_____

Name of Surgery:_____Year:_____

Hospitalizations: (List with dates, excluding the above hospitalizations)

Name of Hospital:_____Year:_____

Name of Hospital:_____Year:_____

Name of Hospital:_____Year:_____

Allergies: (Please Circle If Applicable)

Sulfa Penicillin Cholesterol Medications (statins) Codeine Latex Other **Allergies:**_____

Social History: (Please Circle, If Applicable)

Current Smoker Former Smoker Non Smoker Recreational Drug Use Alcohol Use

Family History: (Please check all that apply)

Problem	Mother	Father	Grandparents (Mat. Or Pat.)	Bro/Sister
Hypertension				
Heart Disease				
Abnormal Cholesterol				
Diabetes				
Colon Cancer				
Liver Disease				
Cancer (List Type)				
Thyroid Problem				

In general do you have any of the following symptoms? (Please Circle, If Applicable)

Trouble Sleeping
Always Tired
Loss of appetite
Weight Loss
Weight Gain
Wheezing
Hepatitis
Colon Cancer
Ulcers
Falls or Stumbling
Runny Nose

Hoarseness
Trouble Swallowing
Sore Throat
Cough
Shortness of breath
Loose Stools
Chest Pain
Nausea
Vomiting/Dry Heaves
Heartburn/Acid Reflux
Recent Labwork

Constipation
Rectal Bleeding
Rectal Pain
Diarrhea
Recurrent Infection
Hemorroids
Black/Bloody Stools
Abdominal Pain
Abdominal Bloating
Pelvic Pain
Recent MRI, CT, Ultrasound, etc

Current Medications:

Name:	Strength/mg:	Amount (1,2,3 Tablets)	Frequency: (1,2,3 Daily)

Are you taking any aspirin, vitamin supplements or alternative medications? Please List

_____

Signature:_____ Date:_____

JAGDISH NACHNANI, M.D.
GASTROENTEROLOGY/LIVER DISEASE
HIGHPOINT HEALTH PARTNERS

Today's Date: _____

Patient Name: _____ DOB: _____

General/Constitutional

Fatigue	O Yes	O No
Fever	O Yes	O No
Night sweats	O Yes	O No
Weight loss	O Yes	O No

Ophthalmologic

Dry eye	O Yes	O No
Pain	O Yes	O No

ENT

Hoarseness	O Yes	O No
Mouth sores	O Yes	O No
Sinus problems	O Yes	O No
Sore Throat	O Yes	O No
Swollen glands	O Yes	O No

Endocrine

Cold intolerance	O Yes	O No
Heat intolerance	O Yes	O No

Respiratory

Cough	O Yes	O No
Hemoptysis	O Yes	O No
Shortness of breath at rest	O Yes	O No
Wheezing	O Yes	O No

Cardiovascular

Swelling of ankles	O Yes	O No
Chest pain at rest	O Yes	O No
Chest pain with exertion	O Yes	O No
Irregular heartbeat	O Yes	O No

Hematology

Blood clotting problems	O Yes	O No
Prolonged bleeding	O Yes	O No

Genitourinary

Blood in urine	O Yes	O No
Painful urination	O Yes	O No

Musculoskeletal

Back pain	O Yes	O No
Muscle aches	O Yes	O No

Skin

Itching	O Yes	O No
Rash	O Yes	O No
Skin lesion(s)	O Yes	O No

Neurologic

Gait abnormality	O Yes	O No
Tingling/numbness	O Yes	O No

Psychiatric

Anxiety	O Yes	O No
Depressed mood	O Yes	O No
Substance abuse	O Yes	O No

Family History

Mother	O Colon Cancer	O Crohn's disease	O Colitis	O Liver disease	Living or Deceased
Father	O Colon Cancer	O Crohn's disease	O Colitis	O Liver disease	Living or Deceased
Siblings	O Colon Cancer	O Crohn's disease	O Colitis	O Liver disease	