ADVANCED GASTROENTROLOGY
DR. B. JEFFREY WALLIS MD, PA

PATIENT DEMOGRAPHICS

Date:_____ Date Of Birth:_____

Name:_____ Social Security:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home #:_____ Cell#:_____ Work:_____

Leave Messages; Please check **Home** __ Appointment __ Billing ___ Medical **Cell** __ Appointment __ Billing ___ Medica

Marital Status:_____ Age:_____ M F Email:_____

Employer:_____ Phone #_____

EMERGECY CONTACT (MANDATORY)

Name:_____ Relationship:_____ Number:_____

INSURANCE INFORMATION

Primary Insurance:_____ ID#:_____ Group #:_____

Policy Holder:_____ Policy Holder D.O.B:_____

Social Security: _____ Type Of Plan: HMO PPO POS Individual Other:_____

Secondary Insurance:_____ ID#:_____ Group #:_____

Policy Holder:_____ Policy Holder D.O.B_____

Social Security: _____ Type Of Plan: HMO PPO POS Individual Other:_____

REFERRAL & PCP INFORMATION

Referred By:_____ Phone:_____ Fax:_____

PCP (Primary Care Doctor)_____ Phone:_____ Fax:_____

PHARMACY INFORMATION

Pharmacy:_____ Phone:_____

Address:_____

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD, PA"

MEDICAL HISTORY

DATE: _____

NAME: _____ DOB: _____ AGE: _____

PLEASE EXPLAIN WHAT BRINGS YOU HERE TODAY:

_____

_____

PLEASE LIST ALL HOSPITALIZATIONS AND/OR SURGERIES:

APPROXIMATE DATE	DIAGNOSIS AND/OR SUGERY	HOSPITAL/DOCTOR	SURGEON

FAMILY HISTORY:

	AGE	ARE THEY ALIVE AND WELL? PLEASE LIST ANY HEALTH PROBLEMS THEY HAVE THAT RUN IN THE FAMILY.	IF DECEASED, PLEASE LIST CAUSE AND AGE
FATHER			
MOTHER			
BROTHER			
BROTHER			
SISTER			
SISTER			

HAVE YOU EVER HAD OR ARE YOU CURRENTLY BEING TREATED FOR: (IF YES, PLEASE CHECK THE APPROPRIATE BOXES)

☐	HIGH BLOOD PRESSURE	☐	HEART ATTACK	☐	ENLARGED HEART	☐	HEART VALVE DISEASE	☐ HEART MURMUR
☐	RHEUMATIC FEVER	☐	ANGINA	☐	CHOLESTEROL	☐	PNEUMONIA	☐ PLEURISY
☐	TB	☐	BRONCHITIS	☐	COUGHING UP BLOOD	☐	ASTHMA	☐ EMPHYSEMA
☐	KIDNEY OR BLADDER INFECTION (CYSTITIS)	☐	SHORTNESS OF BREATH	☐	COLITIS	☐	HEPATITIS	☐ DIABETES MELLITUS
☐	BLOOD IN URINE	☐	KIDNEY STONES	☐	PROSTATE PROBLEMS	☐	FREQUENT HEADACHES	☐ BACKACHES
☐	ARTHRITIS	☐	MIGRAINES	☐	EPILEPSY	☐	SEIZUERS	☐ PASSING OUT OR DIZZY SPELLS
☐	NERVOUSNESS	☐	TROUBLE SLEEPING	☐		☐		☐

OTHER MEDICAL ISSUES BEING TREATED FOR NOT MENTIONED ABOVE: _____

_____

_____

_____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING PROBLEMS? (IF, YES PLEASE CHECK THE APPROPRIATE BOXES)

_____ *TROUBLE WITH SWALLOWING*
_____ *PAIN WITH SWALLOWING*
_____ *IS THE PROBLEM PROGRESSIVELY GETTING WORSE _____YES_____NO*
_____ *HEARTBURN IF SO,_____ LIQUIDS _____ SOLID FOODS_____ INFREQUENTLY_____ ALL THE TIME*
_____ *REGURGITATION IF SO,_____ LIQUIDS_____ SOLID FOODS_____ INFREQUENTLY_____ ALL THE TIME*
_____ *IS THE PROBLEM PROGRESSIVELY GETTING WORSE _____YES_____NO*

DO YOU FREQUENTLY HAVE CHEST PAIN: *_____YES_____NO*
IF YES, PLEASE EXPLAIN THE TYPE OF PAIN, WHEN DOES IT OCCUR, WHAT MAKES IT WORSE, WHAT BRINGS IT ON, AND WHAT RELIEVES IT:
_____

_____

HAVE YOU TAKEN ANY MEDICATIONS FOR THE CHEST PAIN: *_____YES_____NO IF YES, WHAT IS THE MEDICATION AND WHAT WAS THE EFFECTS OF IT:* _____

_____

HAVE YOU RECENTLY EXPERIENCED PAIN IN YOUR STOMACH? (IF YES, PLEASE CHECK THE APPROPRIATE BOXES)

_____ *BURNING OR GNAWING TYPE OF DISCOMFORT*
_____ *SHARP STABBING TYPE PAIN*
_____ *PAIN ACCOMPANIED BY DIARRHEA* _____ *PAIN ACCOMPANIED BY CONSTIPATION*
_____ *OCCURS 1-2 HOURS AFTER MEALS*
_____ *BROUGHT ON BY EATING GREASY, FRIED FOODS*
_____ *IS RELIEVED TEMPORARILY BY ANTACID MEDICATIONS*
_____ *IS RELIEVED BY MILK OR EATING*
_____ *IS WORSENED WHILE EATING OR IMMEDIATELY AFTER*
_____ *IS RELIEVED BY A BOWEL MOVEMENT OR PASSAGE OF GAS*
_____ *AWAKENS YOU AT NIGHT*
_____ *LOSS OF APPETITE*
_____ *VOMITING*
_____ *OTHER*_____

HAVE YOU RECENTLY EXPERIENCED ANY CHANGES IN BOWEL HABITS? (IF YES, PLEASE CHECK THE APPROPRIATE BOXES)

_____ *CRAMPING PAIN IN ABDOMEN*
_____ *CONSTIPATION*
_____ *DIARRHEA*
_____ *PAIN DURING OR AFTER A BOWEL MOVMENT*
_____ *BRIGHT RED RECTAL BLEEDING IF YES, _____INFREQUENTLY _____WITH EVERY BOWEL MOVEMENT*
_____ *BLOOD STREAKED ON OUTSIDE OF STOOL*
_____ *BLOOD MIXED INSIDE THE STOOL*
_____ *BLOOD DRIPPING INTO TOILET BOWL*
_____ *BLOOD SPOTTING ON TOILET PAPER*
_____ *MUCUS IN STOOLS*
_____ *PENCIL THIN STOOLS*
_____ *RIBBONS LIKE STOOLS*
_____ *FLOATING STOOLS*
_____ *BLACK STOOLS IF YES, _____TARRY _____LIQUIDY*
_____ *USE OF STRONG LAXATIVES OR ENEMAS FREQUENTLY*
_____ *OTHER*_____

WOMEN TO COMPLETE BELOW:
AGE MENSTRUAL CYCLE BEGAN: _____ FLOW OF CYCLE: _____ REGULAR _____ MILD _____ HEAVY

DURATION OF PERIOD (HOW MANY DAYS DID IT LAST): _____
WHEN WAS YOUR LAST PERIOD: _____

ARE YOU ALLERGIC TO LATEX? YES or NO

ALLERGIES TO MEDICINE

NAME OF MEDICATION	*REACTION*

DO YOU HAVE A DEFIBRILLATOR OR PACEMAKER? YES or NO

*SO WHAT TYPE*_____

*HAVE YOU HAD A SIGMOIDOSCOPY IN THE PAST? YES or NO (IF SO WHEN)*_____

HAVE YOU HAD A COLONOSCOPY IN THE PAST? YES / NO (IF SO WHEN) _____

*WHAT WAS FOUND (EG? POLYPS)*_____

FAMILY HISTORY: DO YOU HAVE FAMILY MEMBERS WITH COLON CANCER? YES / NO

*IF YES, WHO AND AGE OF DIAGNOSIS?*_____

_____

DO YOU HAVE FAMILY MEMBERS WITH COLON POLYPS? YES / NO

*IF YES WHO AND AGE OF DIANOSIS?*_____

_____

ANY FAMILY MEMBERS WITH OTHER CANCERS (UTERUS, OVARY, OTHER) YES / NO

*IF YES, WHO AND WHAT AGE OF DIAGNOSIS?*_____

_____

*DO YOU HAVE LIVER DISEASE?*_____

*DO YOU HAVE ULCERATIVE COLITIS / CROHNS DISEASE?*_____

*PATIENT SIGNATURE*_____ *DATE*_____

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

REVIEW OF SYSTEMS

PATIENT:_____ D.O.B_____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?
(Circle YES or NO to accurately describe your symptoms.)

CONSTITUTION

WEIGHT GAIN	YES	NO
UNINTENTENTIONAL WEIGHT LOSS	YES	NO
FEVER	YES	NO
FATIGUE	YES	NO
WEAKNESS	YES	NO

OTHER_____

EARS

HEARING LOSS	YES	NO
RINGING IN EARS	YES	NO

OTHER_____

MOUTH

ULCERS	YES	NO
SORES	YES	NO

OTHER_____

NOSE

SINUS TROUBLE	YES	NO
NOSE BLEEDS	YES	NO

OTHER_____

THROAT

SORE THROAT	YES	NO

OTHER_____

EYES

BLURRED VISION	YES	NO
LOSS OF SIGHT	YES	NO

OTHER_____

GASTROINTESTINAL

DIFFICULTY SWALLOWING	YES	NO
HEARTBURN	YES	NO
HIATAL HERNIA	YES	NO

GASTTOINTESTINAL (continued)

INDIGESTION	YES	NO
NAUSEA	YES	NO
VOMITTING	YES	NO
BLACK TARRY STOOLS	YES	NO
ABDOMINAL PAIN	YES	NO
BELCHING/GASEOUSNESS	YES	NO
BLOATING	YES	NO
CONSTIPATION	YES	NO
DIARRHEA	YES	NO
FREQUENT LAXATIVE USE	YES	NO
HEMORRHOIDS	YES	NO
RECTAL BLEEDING	YES	NO
HEPATITIS	YES	NO
LIVER DISEASE	YES	NO
JAUDICE (YELLOW EYES OR SKIN)	YES	NO
GALLSTONES	YES	NO
INGUINAL HERNIA	YES	NO

OTHER_____

HEART

ANKLE SWELLING	YES	NO
ARTIFICIAL VALVE	YES	NO
CHEST PAIN	YES	NO
HEART MURMURS	YES	NO
HIGH BLOOD PRESSURE	YES	NO
HISTORY OF HEART ATTACK	YES	NO
MIRTAL VALVE PROLAPSE	YES	NO
PACEMAKER	YES	NO
PALPITATIONS	YES	NO

OTHER_____

LUNGS

ASTHMA	YES	NO
COUGH	YES	NO
SHORTNESS OF BREATHE	YES	NO
EMPHYSEMA	YES	NO
WHEEZING	YES	NO

OTHER_____

ADVANCED GASTROENTEROLOGY
" DR. B. JEFFREY WALLIS MD PA

REVIEW OF SYSTEMS (CONTINUED)

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?
(Circle YES or NO to accurately describe your symptoms.)

GYNECOLOGY (if applicable)
LAST MENSTRUAL PERIOD_____
POST MENOPAUSAL YES NO
UTERINE CANCER YES NO
CERVICAL CANCER YES NO
OTHER_____

URINARY
BLOOD IN URINE YES NO
FREQUENT URINARY YES NO
TRACT INFECTIONS YES NO
KIDNEY STONES YES NO

INFECTIOUS DISEASE
HAVE YOU HAD TUBERCULOSIS YES NO
HAVE YOU HAD HISTOPLASMOSIS YES NO

MUSCULOSKELETAL
ARTHRITIS YES NO
BACK PAIN YES NO
JOINT PAIN YES NO
OTHER_____

SKIN
RASH YES NO
ITCHING YES NO
OTHER_____

NEUROLOGICAL
DIZZINESS YES NO
SEIZURE DISORDER YES NO
EPILEPSY YES NO
OTHER_____

PSYCHIATRIC
ANXIETY YES NO
DEPRESSION YES NO
TROUBLE SLEEPING YES NO
OTHER_____

ENDOCRINE
DIABETES YES NO
THYROID DISEASE YES NO
OTHER_____

HEMATOLOGIC/LYMPHATIC
ABNORMAL POST SURGICAL BLEEDING YES NO
ANEMIA YES NO
EASY BRUISING/BLEEDING YES NO
OTHER_____

ALLERGIC/IMMUNOLOGIC
ALLERGIES (NON MEDS) YES NO
FREQUENT INFECTIONS YES NO
HIV / AIDS YES NO
OTHER_____

ARE YOUR OUTSIDE MEDICAL RECORDS (check YES or NO) **RECORDS REQUESTED?**

1. PHYSICIANS NAME & PHONE#_____ YES NO

2. HOSPITAL NAME_____ YES NO

3. OTHER FACILITY (eg. Xrays, labs, endoscopy)_____ YES NO

PATIENT SIGNATURE_____ DATE_____

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

PRESCRIPTION & OTC MEDICATION LOG

PATIENT NAME: _____ **DOB:** _____

PHARMACY/LOCATION: _____

ALLERGIES: _____

PRESCRIPTION & OTC MEDICATION	STRENGTH	DOSAGE	DIRECTIONS	PRESCRIBING PHYSICIAN

HEPATITIS-C SCREENING

- *Are you a baby boomer- born between 1945-1965?*
  Yes *No*
- *If yes, are you aware that your age group is recommended by the Center for Disease Control, (CDC), and Public Health Service (PHS) to have Hepatitis C screening once?*
  Yes *No*
- *Have you ever received blood products before 1987?*
  Yes *No*
- *Have you ever received blood transfusions or organ transplant before July 1992?*
  Yes *No*
- *Have you ever injected drugs, even one time?*
  Yes *No*
- *Do you have HIV?*
  Yes *No*
- *Have you ever been on kidney dialysis for several years?*
  Yes *No*
- *Where you born to a mother with HIV?*
  Yes *No*
- *Were you ever a health/public safety worker and got stuck with a needle or sharp object with blood from a person with known/unknown Hepatitis C?* *Yes* *No*
- *Have you ever received vaccinations against Hepatitis?*
  Yes *No*

If you have answered yes to any of these questions would you like to be screened for Hepatitis C?
Yes *No*

Name: _____

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

SOCIAL HISTORY

Marital status: ___Single ___Married ___Separated ___Divorced ___Widowed

Who do you live with? _____

Occupation: _____

Do you currently drink alcohol? ____ *Yes* ____ *No*

Did you drink alcohol in the past? ____ *Yes* ____ *No*

How many drinks per day? ____

How many drinks per week? ____

Do you have a problem with alcohol use? ____ *Yes* ____ *No*

If yes, please explain _____

Do you have problem with drug use? ____ *Yes* ____ *No*

If yes, please explain: _____

Do you currently smoke? ____ *Yes* ____ *No*

Did you smoke in the past? ____ *Yes* ____ *No*

If yes, when did you quit? _____

Number of packs per day? _____

How many years? _____

Do you drink caffeine? ____ *Yes* ____ *No*

Number of cups per day of caffeinated coffee? _____

Number of cups per day of caffeinated tea? _____

Number of cups per day of caffeinated soda? _____

Patient Signature: _____ *Date:* _____

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

CONSENT FOR RELEASE OF INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I, _____, hereby authorize Advanced Gastroenterology to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Advanced Gastroenterology can refuse to treat me.

I have received a copy of the Notice of Privacy Practice, which more fully describes its use, and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I may revoke this consent at any time by notifying Advanced Gastroenterology in writing, but if I revoke my consent, such revocation will not affect my actions that Advanced Gastroenterology took before receiving my revocation.

I understand that Advanced Gastroenterology has reserved the right to change their privacy practice and that I can obtain such changed notice upon request. I understand that I have the right to request that Advanced Gastroenterology restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health care operations. I understand that Advanced Gastroenterology does not have to agree to such restrictions, but that once such restrictions are agreed to Advanced Gastroenterology must adhere to such restrictions.

DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Please be advised that one of the requirements under the Health Insurance Portability and Accountability Act (HIPAA federal privacy law) requires you to authorize/designate below which individuals (relatives, this includes spouse or significant other, and/or friends) we can speak with about your healthcare treatment, healthcare payments, and healthcare operations. I authorize/designate the following individuals:

**NAME:_____RELATIONSHIP:_____PHONE:_____*

**NAME:_____RELATIONSHIP:_____PHONE:_____*

**NAME:_____RELATIONSHIP:_____PHONE:_____*

I understand that I can change or revise my designees at any time by notifying Advanced Gastroenterology in writing.

Patient Signature:_____ Date:_____

ADVANCED GASTROENTEROLOGY
DR. B. JEFFREY WALLIS, MD,PA
6152 W CORPORATE OAKS DRIVE
CRYSTAL RIVER, FL 34429
PHONE 352-564-3900 FAX 352-564-3906

MEDICAL RECORDS RELEASE

TO:_____

_____

_____

PHONE:_____ FAX:_____

PLEASE RELEASE MY:

- ☐ COMPLETE MEDICAL RECORD
- ☐ LABS
- ☐ DIANOSTIC IMAGING REPORTS
- ☐ CONTINUITY OF MEDICAL CARE
- ☐ OTHER:_____

_____

I hereby authorize Advanced Gastroenterology to obtain/release my health information. I understand this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan, or health care provider, the released information may no longer be protected by federal privacy regulations. I understand I may revoke this authorization to release information at anytime by given written notice.

From: _____
Advanced Gastroenterology
Dr. B. Jeffrey Wallis, MD, PA
6152 W Corporate Oaks Drive
Crystal River, FL 34429
Telephone 352-564-3900 Fax 352-564-3906

Patient to complete below:

Patient Name (print)_____

Date Of Birth:_____

Social Security:_____

Patient/Guardian Signature:_____

Date: _____

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

PATIENT RESPONSIBILITY

Dear Patient,

Enclosed is a packet of paperwork that we need you to complete and bring back with you for your new patient appointment. ***Please arrive 20 minutes early and provide the completed paperwork which includes but not limited to: your driver's license, insurance cards, medical records and referral to the receptionist upon your arrival.***

Payment is always expected at time of service. Copays, deductibles, self-pays, outstanding balances and any financial obligations are to be paid upon arrival before going back to be seen by the physician or nurse practioner.

It is the patient's responsibility to provide our office current and up to date changes in names, addresses, telephone numbers and insurances immediately.

In order to permit a comprehensive, accurate and prompt evaluation of your condition, ***it is the patients responsibility and vital that all of your most recent medical records, i.e. most recent lab work, procedure & pathology reports, history & physical and diagnostic imaging reports be sent to our office prior to your appointment.***

Referral/Authorization:

It is the patient's responsibility to provide our practice with any referrals needed and to ensure that we receive the referral prior to your appointment date from your primary care physician in order to be treated by our physician. ***If the referral is not received prior to your scheduled appointment date or is not in hand when you arrive, we will have to reschedule your appointment until a referral is obtained for treatment.***

Patient Signature: _____

Date: _____

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

FINANCIAL POLICY

Insurance:

As your physician, our relationship is with you and not your insurance company. While filing of claims is a courtesy that we extend to all our patients, all charges are strictly your responsibility for all dates of services rendered. Therefore, it is mandatory for you to research your coverage and benefits with your insurance carriers ensuring that Advanced Gastroenterology is in network and that you are eligible for all services we render before you make your appointment with our practice. You will be responsible to pay in full if Advanced Gastroenterology is out of network and for any non-covered services we provide you.

If we are in network and participate with your insurance company, you will be expected to pay any contracted copays, coinsurance and deductibles at the time of service. It is your responsibility to ensure your insurance information is current and that you are eligible at the time of service. *We will require a copy of your current insurance cards before services are performed along with your referral/authorization that you are responsible to obtain and provide to our practice.*

If a procedure is done at the time of your office visit the procedure is not included in the office visit. *You are responsible for payment regardless of any non-participating insurance company's determination of usual and customary rates.*

Self-Pay (No Insurance Coverage):

If you do not have insurance, payment in full is expected at time of service unless prior payment arrangements have been made with our billing department. *If such an arrangement has been approved, you will be required to pay the agreed upon amount upon arrival for each appointment.*

Checks Returned:

It is our practice policy to charge you a $35.00 fee for any checks that are returned to our bank for non- sufficient funds.

Patient Signature: _____

Date: _____

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

No Call/No Show Policy

Dear Patients;

APPOINTMENTS

Effective Immediately, Advanced Gastroenterology implemented a No Call/No Show Policy (NCNS) which also includes cancelling or re-scheduling appointment less than 48 hrs notices. Please understand that you will be considered a NCNS if you do not call and cancel your scheduled appointment within 48 hours or if you simply do not show up for your appointment. There will be a $105.00 NCNS charge applied to your account. Payment of the NCNS charge must be made in cash, credit card or check before a further appointment is scheduled.

PROCEDURES

Effective immediately on scheduled procedures will require a 73 hour notice of cancellation/reschedule and if you no call/no show on your appointment. A $150.00 charge will be applied to your account. Payment of the charge must be made in cash, check or credit card before further appointment is scheduled.

This policy applies to all patients with all insurance carriers or private pay. Our follow-up protocols are based on the years of experience and level of care we provide you with the highest standard possible. ***Keeping your follow-up appointments is an important part of the relationship between you and Advanced Gastroenterology when you agree to become a patient.***

Advanced Gastroenterology will make every effort to remind you of your scheduled appointment as a curtiousy, but ultimately it's the patient responsibility. . ***Please keep ALL your contact phone numbers, home address and email addresses updated each time you visit our office or simply give us a phone call to make these changes immediately.***

This policy has been implemented to help us provide the best quality of care to all of our patients. If for any reason you cannot keep your appointment, please call as soon as possible to cancel or reschedule. ***Please give us at least 48 hour's /72 hours' notice so we may use that appointment to attend to another patient. Please respect the doctor's time and the other patients in our practice.***

I _____ ***have read the (NCNS) policy agreement and understand what is expected of me and that if I do not notify the office of the cancellation/reschedule within 48 hours or do not show up for office appointment/73 hours for procedure or do not show up,, I will be charged a $105.00 for the office appointment/$150.00 for procedure No Call No charge.***

Signature: _____ *Date:* _____

Revised 11/23/15ss

Notice of Privacy Practices for Protected Health Information (HIPAA)

"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information". Please Review It Carefully!

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors.
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Worker's compensation
- Disaster Relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights:

You Have The Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days. You may also get an electronic copy if we have one available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supercede the typical disclosures noted above. You may revoke or restrict the consent.
- Restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for the healthcare item or service.
- Request confidential communications. All communications in our office are confidential. You may specifically-request that all communications be confidential with a written request directed to our office.
- Not to have your protected health information sold for marketing purposes.
- Opt out of receiving fund-raising communications.
- Be notified following a breach of your unsecured protected health information.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We May Contact You for Appointment Reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our <u>PRIVACY OFFICER</u> at our office.

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

Effective Date of Notice: **Jan 2018**

Amended Dates:

ADVANCED GASTROENTEROLOGY
"DR. B. JEFFREY WALLIS MD PA"

Notice of Privacy Practices Acknowledgement Form

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the material, please sign in the space provided below.

PATIENT RIGHTS

As a patient, you have the right to inspect, copy, amend, request a restriction of, or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of an accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. You may request that we communicate with you only in a specific manner (i.e., "only communicate with me at my work telephone number").

PROVIDER RIGHTS

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

Patient Name (printed) Date of Birth

Patient/Guardian Signature Date

For Staff Use Only:

Written acknowledgement was not obtained for the following reasons:

Staff Name Staff Signature Date

DIRECTIONS

HOMOSASSA & SPRING HILL AREA

At the light of homossa trail make a LEFT ONTO 44 WEST "OR" At the light on rock crusher make a LEFT ONTO 44 West
At Vanness & Vanness Atty's Office MAKE a RIGHT (N Meeting Tree Blvd)
Make your 1st RIGHT (W Corporate Oaks Dr) bear to the right and follow the road, look for a small sign (right side)"Quest Diagnostic" Make a RIGHT into the parking lot..walk up the sidewalk 1st Office on Your RIGHT "Advanced Gastroenterology, Dr. Wallis"

INVERNESS

Head WEST on 44...when you see the green sign " rock crusher next light" as soon as you pass the sign make a RIGHT (W Corporate Oaks Drive) follow the road around the bend make a LEFT into the parking lot walk up the sidewalk 1st Office on Your RIGHT "Advanced Gastroenterology, Dr. Wallis"...(same parking lot as Quest Diagnostics)

CRYSTAL RIVER

Head East on 44
Go through the traffic light (n Meadowcrest) pass the Winn Dixie on your left side
Make a LEFT (N Meeting Tree Blvd) At Vanness & Vanness Atty's Office
Make your 1st RIGHT (W Corporate Oaks Dr)) bear to the right and follow the road, look for a small sign (right side)"Quest Diagnostic" Make a RIGHT into the parking lot..walk up the sidewalk 1st Office on Your RIGHT "Advanced Gastroenterology, Dr. Wallis"

Hwy 486.. BEVERLY HILLS, CITRUS SPRINGS

Turn LEFT onto Meadowcrest
At the 3rd stop sign MAKE A LEFT (N Meeting Tree Blvd) go through stop sign and around bend.. Where the sign "DO Not Enter" is MAKE A LEFT (W Corporate Oaks Drive)..) bear to the right and follow the road, look for a small sign (right side)"Quest Diagnostic" Make a RIGHT into the parking lot..walk up the sidewalk 1st Office on Your RIGHT "Advanced Gastroenterology, Dr. Wallis"