R. Sameer Islam, M.D, Board Certified Gastroenterology• Elena Sheets, APRN-FNP-C • Kenda Wines, APRN-FNP

4505 82nd ST, Suite 5, Lubbock, TX 79424 Office (806) 696-4440 Fax (806) 696-4441 Website: LubbockGastro.com

Date:__________ **Name:**____________________________ **Phone number:**______________________ **DOB:**________________

Reason for visit:____

☐ Married ☐ Single ☐ Divorced **Number of Children**:____________ **Occupation**:__________________ **Education**:____________

Emergency Contact/MPOA: ____ **Phone Number**: ______________________________

Allergies/Reactions: (please list) NO Medication allergies ☐ Latex: No Metal: No Contrast Dye: No

Medications/Strength/How Often: NO Home Medications ☐

<u>Check those that apply:</u>

☐Abdominal Pain ☐ Regurgitation ☐ Diarrhea ☐ Constipation ☐ Appetite Changes

☐ Heartburn ☐ Nausea/Vomiting ☐ Weight loss ☐ Fever ☐ Jaundice

☐ Gallstones ☐ Swallowing Difficulty/Pain ☐ Anemia ☐ Bloating ☐ Polyps

Have you ever had a colonoscopy? ☐ Yes ☐No If yes, When, and where: __________________________

Do you have a history of colon polyps? ☐ Yes ☐No If yes, how many? ______________________________

Family History of Colon Cancer? ☐ Yes ☐No If yes, Who? __________________________________

Do you have hemorrhoids? ☐ Yes ☐No If yes, do they bother you now? ☐ Yes ☐No

Do you have acid reflux? ☐ Yes ☐No If yes, is it controlled by Meds? ☐ Yes ☐No

Have you ever been diagnosed with Hepatitis? ☐Yes ☐ No If Yes, Which type:____

Do you drink alcohol or beer? ☐ Yes ☐ No ☐ Past If Yes, What Kind? ☐ Beer ☐ Wine ☐ Other__________ Last Used:

Do you use tobacco? ☐ Yes ☐ No ☐ Past If Yes, What Kind? ☐ Cigarettes ☐ Vape ☐ Chew How many years? ________
How many packs per day? ______

Do you use recreational drugs? ☐ Yes ☐ No ☐ Past If Yes/Past, What kind? ____________________ Last Use: ______________

Do you use IV drugs? ☐ Yes ☐ No ☐ Past If Yes/Past, What kind? ____________________ Last Use: ______________

Do you tire easily? ☐ Yes ☐ No Do you use ambulatory assistive devices ☐ No ☐ Cane ☐Walker ☐ Wheelchair/Scooter

Are you able to walk 2 blocks? ☐ Yes ☐ No Climb a flight of stairs? ☐ Yes ☐ No Run a short distance? ☐ Yes ☐ No

Are you able physically active? ☐ Yes ☐ No Recent weight loss? ☐ Yes ☐ No Become short of breath easily? ☐ Yes ☐ No

Do you need help getting dressed? ☐ Yes ☐ No Any recent falls? ☐ Yes ☐ No Have chest pain with activity? ☐ Yes ☐ No

Do you **wear:** ☐ Glasses ☐ Contacts ☐Hearing Aid

Please **Mark** all pre-existing conditions that apply to YOU: (check If applicable)

Eyes

☐Cataract
☐Glaucoma
☐Macular Degeneration
☐Yellow Eyes

Cardiovascular

☐Aneurysm
☐Chest Pain
☐CHF (Heart Failure)
☐Heart Attack
☐Heart Disease
☐High Blood Pressure
☐High Cholesterol
☐Irregular Heartbeat (SVT, A-fib)
☐Mitral Valve
☐Pacemaker/Defibrillator
☐Peripheral/Vascular Disease
☐Phlebitis/Blood Clots
☐Heart Surgery/Stents
☐Raynaud's
Other:____________

Respiratory

☐Asthma Use Inhaler ☐Yes ☐ No
☐COPD Use Inhaler ☐Yes ☐No
☐Cystic Fibrosis
☐Frequent Bronchitis
☐Pneumonia
☐Tuberculosis
☐Oxygen ☐Daily ☐Nightly
Other:____________

Gastrointestinal

☐C-diff
☐GI Bleed
☐Heartburn / GERD
☐Hepatitis ☐A ☐B ☐C
☐Irritable Bowel / IBS
☐Liver Disease – Cirrhosis
☐Ulcer Disease
Other:______________

Genitourinary

☐Kidney Disease – Dialysis? No
☐Kidney Stone
☐Sexually Transmitted Infection
☐Urinary Tract Infection
Last Menstrual Period ______________
☐Birth Control
Other:______________

Musculoskeletal

☐Arthritis
☐Back Injury
☐Back Pain
☐Fibromyalgia
☐Osteoporosis
Other:______________

Endocrine/Metabolic

☐Diabetes – Type 1 or 2
☐Thyroid Disease
☐Heat/Cold intolerance
Other:______________

Neurological

☐Frequent Headaches
☐Migraines
☐Multiple Sclerosis
☐Seizures
Date of last seizure_____
☐Stroke
☐TIA
☐Guillen Barre
☐Myasthenia Gravis

Psychiatric

☐Addictions
☐Anxiety
☐Depression
☐Mood Swings / Bipolar
☐Panic Attacks
☐Psychosis /Schizophrenia
☐PTSD

Hematologic

☐Anemia
☐Bleeding / Clotting Disorder
☐DVT
☐Sickle Cell Anemia
Blood transfusion
☐Yes☐No
Other:______________

Any other medical conditions ________
____
____

Immunologic

☐AIDS/HIV
☐Immunosuppression
☐Rheumatic Fever
☐Typhoid Fever
Other:______________

Oncological

☐Breast Cancer
☐Colon / Rectal Cancer
☐Leukemia
☐Lung / Bronchial Cancer
☐Lymphoma
☐Prostate Cancer
☐Urinary/Bladder Cancer
Other:______________

Wound Healing

☐MRSA/ORSA/VRE
☐Resistant Organism
☐Slow to Heal
Other:______________

Implanted Medical Device

☐Pacemaker
☐AICD (defibrillator)
Other:______________

Family History (check any that apply)

☐ Anemia ☐ Crohn's ☐ Ulcerative Colitis ☐ Celiac Disease ☐ Colon Cancer ☐ Pancreatitis ☐ Ulcers ☐ Liver Disease

☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Asthma ☐ Kidney Disease ☐ Tuberculosis ☐ Epilepsy

☐ Gastric Cancer ☐ Pancreatic Cancer

Other:____

____

Have you ever been diagnosed with Sleep Apnea?

If yes do you wear a CPAP machine? ☐ Yes ☐ No

SURGICAL PROCEDURES: (circle If applicable or write In)

☐ Appendectomy ☐ Tonsillectomy ☐Hysterectomy ☐Tubal ligation ☐ C-Section ☐Gallbladder ☐ Heart Bypass ☐Colon Resection

Other surgery: ____

Any surgical procedures that would Impair your airway? ____

Has anyone **ever** told you that you **were** difficult to intubate (place a breathing tube for surgery)? ☐Yes ☐No

Have you or your family *ever* had problems with anesthesia? ☐ Yes ☐ No If Yes, what: ______________________________

Is there anything else we need to know to take better care of you? ______________________________

Patient Registration

Today's Date __________ Reason for today's visit ____

PCP NAME:____

Reason Primary Physician ☐ Patient unavailable ☐ Patient Undecided ☐ Do not want to identify ☐ Unsure of PCP Name

Section A: Patient information

Patients Legel Name First _______________ M I______Last ________________________________ Preferred

First Name _________________________________

Mailing Address ______________________________________City ____________________ State ________ZIP_______

Home Phone ____________________ Cell Phone _____________Misc. Phone # ___________Type:__________

DOB: _____________Social Security # _______________________________Sex ☐M ☐F Marital Status _______

Preferred method of contact ☐Home Phone ☐ Cell Phone ☐Email

Email Address ______________________________ Preferred Language ______________________________

Race: ☐ American Indian/Alaska Native ☐Asian ☐ Black/African American ☐Native Hawaiian/Pac Islander ☐White ☐ No Reply

Ethnicity: ☐ Hispanic ☐ non-Hispanic ☐ No Reply

Emergency Contact

In case of an emergency, please contact:____________________________________

Relationship to Patient: ____________________________ Phone Home or Cell:________________

Section B: Guarantor Information (Responsible Party)
If any information is the same as above, please indicate by writing "same"

Patient Relationship to Guarantor____

Guarantor 's legal Name First_________________________ M I____________ Last_________________DOB________

Address________________________________ City_________________________ State_____________ Zip__________

Home Phone______________________ Cell Phone________________________ Social Security Number_____________

Section C: Insurance Information
Please provide a current copy of your insurance card

Name of Insurance Carrier ______________________

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐ Other

Please Complete All Blanks

Lubbock Gastroenterology

Patient Name: ______________________________ Phone#_________________ DOS: ___________________

CONSENT TO TREATMENT

I consent to receive medical and health care services, including diagnostic procedures, examinations, x-rays, anesthesia, or medical or surgical treatment, provided under the Instructions of the Lubbock Gastroenterology physician(s), employees, and other health care providers as they deem reasonable and necessary. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I authorize Lubbock Gastroenterology and advanced practice providers to e-prescribe my prescriptions and request my prescription medication history from other healthcare providers or third-party pharmacy payers. I understand that this means Lubbock Gastroenterology and *my* physicians and advanced practice providers may send or receive my prescription electronically. My medical records and prescriptions will also be made available to other healthcare providers through Health Information Exchanges (HIEs).1 may opt out of participating In HIEs by completing an opt-out form at registration or by calling 806-696-4440 to obtain a form by fax, mall or email.

I understand that this Consent to Treatment will be valid and remain In effect as long as I attend or receive services from Lubbock Gastroenterology, unless revoked by me In writing. Any revocation will not be effective until received by Lubbock Gastroenterology.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

l acknowledge that I am legally responsible for all charges billed to me for the medical and health care services provided to me by Lubbock Gastroenterology. I assign all of my rights, title, and Interest in all Insurance benefits otherwise payable to me for medical or health care services to Lubbock Gastroenterology. I authorize direct payment to Lubbock Gastroenterology of any insurance benefits payable to me or on my behalf for medical or health care services furnished to me. I understand that I am responsible for knowing the terms of my insurance benefits and certify that the Information given regarding my insurance is accurate and current to the best of my knowledge. I understand my insurance company may not approve or reimburse my medical services In full. I promise to pay Lubbock Gastroenterology all charges billed to m@ for the medical and health care services received that are not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/· Medicaid, my insurance company, or other third-party payor. I understand that payment may be due at the time of service for any medical and health care services not covered by my insurance company, if *my* account is referred to an attorney or outside agency for collection, I agree to pay reasonable attorneys 'fees and collection expenses.

I understand that I may be asked to pay a deposit prior to a visit and/or obtain a referral, if needed prior to a visit.

I understand that this Financial Responsibility/Assignment of Benefits will be valid and remain in effect as long as I attend or receive services from Lubbock Gastroenterology.

I certify that I have read and understand this Information and that all *of* my questions have been answered to my satisfaction.

______________________________	________________	__________	__________
Patient/Authorized Legal Representative Signature	Relationship to Patient	Date	Time
______________________________	________________________		
Printed Name	Witness/Translator		

January 20, 2024

Annual Attestations and Authorizations, NPP Consent

Confidential Communication Request

______ Permission to give verbal protected health information or leave a message with the following person(s)

Example: Family members, friend, personal caregiver, etc. *Do not list medical providers involved in your care.*

Name: ___________________________ Relationship: ______________ Phone#: ___________________

Name: ___________________________ Relationship: ______________ Phone#: ___________________

Lubbock Gastro Portal:

The portal is a safe and convenient system that allows you to communicate with your healthcare provider and access your medical records. I have been presented with the information regarding the Lubbock Gastro Patient Portal. Please provide your email as this will be the main form of communication.

Email:____

I consent to receive email, text, and or voice messaging from Lubbock Gastroenterology to remind me of an appointment, for surveys about my experience with the healthcare team, or to provide general reminders or information about new services.

Lubbock Gastroenterology **does not** charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

I understand this authorization and consent form will be valid and remain in effect indefinitely unless otherwise revoked by me in writing. Any revocation will not be effective until received by Lubbock Gastroenterology.

Notice of Privacy Policy

I acknowledge that I have received a copy of the Notice of Privacy Policy.

Patient/Legally Authorized Patient Representative Signature: ___________________________________

Relationship to Patient: _______________________

Printed Name: ______________________________________ Date: ______________________________

Follow – up Appointments

"I understand that all of my follow up's will be with the Nurse Practioners per Dr. Islam's discretion. If Dr. Islam deems it necessary to have the follow up with him; he will let the front staff know."

Patient/Legally Authorized Patient Representative Signature: ___________________________________

Relationship to Patient: _______________________

Printed Name: ______________________________________ Date: ______________________________

LUBBOCK GASTROENTEROLOGY

CANCELLATION/NO SHOW OFFICE **POLICY**

PLEASE READ CAREFULLY

Thank you for trusting your medical care to Lubbock Gastroenterology. When you schedule an appointment with Lubbock Gastroenterology, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment *or* procedure, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This will **give** us time to schedule another patient who maybe waiting for an appointment. Our office cancellation/no show policy is below. **All credit cards will need to be kept on file.**

- When a patient fails to show or cancels/reschedules their appointment without at least 24 hours notice will be considered a **NO SHOW** and will be charged a **NO SHOW FEE** of $25. If a patient cancels on the day of their appointment a **CANCELLATION FEE** of $25 will be charged/billed to your credit card on file before the appointment is rescheduled.

- Any patient who fails to notify our office at least 24 hours prior to their missed appointment **3 times** will be dismissed from Lubbock Gastroenterology and will need to contact their Primary Care Provider (PCP} for a referral to another gastroenterologist.

- When a patient fails to notify our clinic at least 48 hours prior to a scheduled procedure it will be considered a **NO SHOW.**

- There will be a **$250 charge** for those who do not keep their **procedure appointment or cancel with less than 48 hours and $350 for doubles (Colon & EGO).** Procedure slots are very limited and by canceling in a timely manner, you will be helping other patients receive the care they need and deserve. Your procedure will not be rescheduled until the fee is paid in full.

I have read and understand the Lubbock Gastroenterology Cancellation/No Show Polley and agree to Its' terms.

Signature	Date
Witness	Date

Updated 11-01-202

NOTICE OF PRIVACY PRACTICES (NPP)
THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY
UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI)

Lubbock Gastroenterology is a clinically integrated healthcare setting and constitute an organized healthcare arrangement under HIPAA. This arrangement involves participation of legally separate entities in the delivery of healthcare services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement will be able to access and use your PHI to carry out treatment, payment, or healthcare operations.

LGLA is required by Texas and Federal Law to maintain the protected health information, to provide individuals with LGLA's Notice of Privacy Practices, and to notify the individuals involved if the individual's unsecured protected health information is used and/or disclosed in a manner not permitted by Texas or Federal Law.

HOW WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION (PHI)

A. **The following uses do NOT require your authorization, except where required by Texas Law.**
   1. **For treatment:** your PHI may be discussed by caregivers to determine our plan of care. The physicians, nurses, medical students, and other healthcare personnel may share PHI in order to coordinate the services you may need.
   2. **To obtain payment:** We may use and disclose PHI to obtain payment for our services from you, an insurance company, or a third party.
   3. **For healthcare operations:** We may use and disclose PHI for hospital operations. For example, we may use the information to review our treatment and services and to evaluate the performance of our staff in caring for you.
   4. **For public health activities:** We report to public health authorities as required by law, information regarding births, deaths, various diseases, reactions to medications and medical products.
   5. **Victims of abuse, neglect, domestic violence:** Your PHI may be released as required by law to the appropriate Texas agencies when cases of abuse and neglect are suspected.
   6. **Health oversight activities:** We will release information for federal or state audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, as required by law.
   7. **Judicial and administrative proceedings:** Your PHI may be released in response to a subpoena or court order.
   8. **Law enforcement:** we may release your PHI as required by law for certain types of wounds.
   9. **Active Duty and Retired Military:** we may release your PHI to the Department of Defense or other governmental agency.
   10. **National Security purposes:** we may release your PHI for national security and intelligence investigations**.**
   11. **Uses and disclosures about patients who have died:** We provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.
   12. **For purposes of organ donation:** As permitted by law, we will notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
   13. **Research:** We may use your PHI if the Institutional Review Board (IRB) reviews for research, approves and establishes safeguards to ensure privacy.
   14. **To avoid harm:** In order to avoid a serious threat to the health or safety of a person or the public, we may release limited information to law enforcement personnel or persons able to prevent or lessen such harm.
   15. **For worker's compensation purposes:** We may release your PHI to comply with worker's compensation laws.
   16. **Health Communication:** We may send you information on the latest treatment, support groups, and other resources affecting your health.
   17. **Fundraising activities:** We may use your PHI to communicate with you to raise funds to support healthcare services and educational programs we provide to the community. You have the right to opt out of receiving such fundraising communications.
   18. **Appointment reminders and health-related benefits and services:** We may contact you with a reminder that you have an appointment for check-up or treatment.

B. **You may object to the following uses of PHI:**
   1. **Information shared with family, friends, or others:** Unless you object, we may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare.
   2. **Health Information Exchanges:** We may share information that we obtain or create about you with other healthcare providers or other healthcare entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges (HIEs) in which we participate. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may opt out of the HIE and disable access to your health information available through the HIE by contacting LGLA, 806-696-4440, to obtain and complete an Opt-Out form.

C. **Your prior written authorization is required to release your PHI in the following situations:**

1. Any uses or disclosures beyond treatment, payment, or healthcare operations and not specified in Parts A & B.
2. Psychotherapy notes, marketing, and the sale of PHI.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

Although your health record is the physical property of LGLA, the information belongs to you, and you have the following rights with respect to your PHI:

A. The right to request limits on how we use and release your PHI: You have the right to ask that we limit how we use and release your PHI. We will consider your request, but we are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Your request must be in writing and state (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; (3) to whom you want the limits to apply, for example, disclosures to your spouse; and (4) an expiration date. 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.

B. The right to choose how we communicate PHI to you: You have the right to request that we communicate with you about PHI in a certain way or at a certain location (for example, sending information to your work address rather than a home address). You must make your request in writing and specify how and where you wish to be contacted.

C. The right to see and get copies of your PHI: You have the right to inspect and receive a copy of your PHI, which is contained in a designated record set that may be used to make decisions about our care. You must submit your request in writing. If you request a copy of the information, we may charge a fee for copying, mailing, or other costs associated with your request. We may deny your request to inspect and receive a copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

D. The right to get a list of instances of when and to whom we have disclosed your PHI: this list **may not** include uses such as those made for treatment, payment, or healthcare operations, directly to you, to your family, or in our facility directory as described above in this NPP. This list also **may not** include uses for which a signed authorization has been received or disclosures made before Jan 11, 2001.

E. The right to amend your PHI: If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we amend the existing information or add the missing information. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is correct and complete or another facility's report.

F. The right to receive a paper or electronic copy of this notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time. For the above requests please contact:
Compliance/Privacy Officer
4505 82nd St, Ste#5
Lubbock, Texas 79424
Phone Number: (806) 696-3459

G. The right to revoke an authorization: If you chose to sign an authorization to release your PHI, you can later revoke that authorization in writing. This will stop any future release of your health information except as allowed or required by law.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think your privacy rights may have been violated, or you disagree with a decision we made about access to your PHI, you may file a complaint with the office listed in the next section of this Notice. **Please be assured that you will not be penalized and there will be no retaliation for voicing a concern or filing a complaint. We are committed to the delivery of quality healthcare in an environment that is confidential and private.**

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice or any complaints about our privacy practices, please call LGLA 806-696-3459

In writing: Compliance/Privacy Officer; 4505 82nd St, Ste#5, Lubbock, TX 79424

You may also send a written complaint to the Secretary of the Department of Health and Human Services. The address will be provided at your request.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time. We also reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. The Notice will always contain the effective date. You may also view the current Notice at any time on the web at: http//www.umchealthsystem.com, under the "For Patient" tab.

EFFECTIVE DATE OF THIS NOTICE

This Notice went into effect on January 1,2021.