Permian Digestive Disease Center

Indira Donepudi, M.D.
2010 W Ohio Ave • Midland, TX 79701
Phone (432) 704-5442 • Fax (432) 704-5443

PATIENT INFORMATION

Last Name:	First:		Middle:
Preferred Name:	Date of Birth:	Age:	Sex: [ ] M [ ] F
Marital Status (circle one) Single / Married / Divorced / Separated / Widowed	Social Security #: **REQUIRED FOR PROCEDURES**		
Home Phone #:	Cell Phone #:	E-mail Address #:	
Mailing Address:	City/ State:	Zip:	
Occupation:	Employer:	Employer Phone: (optional)	

EMERGENCY CONTACT

1.	Relationship:	Phone#:
2.	Relationship:	Phone#:
3.	Relationship:	Phone#:

INSURANCE

PRIMARY INSURANCE: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Policy Holder's DOB: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Policy Holder's DOB: _____

Policy Number: _____ Group Number: _____

PHARMACY

Preferred Pharmacy: _____ Address: _____

Phone #: _____

PRIMARY HEALTH PROVIDER

Primary Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Do you have any Drug Allergies? YES NO

If YES, Please List:

_____

_____

HEALTH HISTORY

MEDICATIONS

List all prescription medications, including over the counter medicines

_____

_____

_____

_____

_____

_____

_____

Circle *any medical conditions that apply to you (Including past conditions)*

AIDS/HIV	GERD/Reflux
Alcoholism	Gout
Anemia	Heart Condition
Arthritis	Hepatitis Type _____
Anxiety Disorder	Heart Attack
Asthma	Hernia
Bleeding Disorders	High Cholesterol
Blood Transfusions	High Blood Pressure
Cancer	History of Colon Polyps
Cirrhosis	Kidney Stones/ Kidney Disease
COPD	Liver Disease
Colon Cancer	Mental Problems
Diverticulitis/Diverticulosis	Thyroid Problems
Diabetes	Ulcers

EXERCISE LEVEL

[ ] None
[ ] Moderate
[ ] Daily

STRESS LEVEL

[ ] None
[ ] Low
[ ] Medium
[ ] High

CAFFIENE INTAKE

[ ] None
[ ] Moderate
[ ] Daily

DIET

[ ] Regular
[ ] Diabetic
[ ] Vegetarian
[ ] Gluten Free
[ ] Other

Have you ever used illegal drugs?
YES NO

Do you have any tattoos?
YES NO

Do you have any body piercings?
YES NO

Are you sexually active?
YES NO

Check *any family medical conditions that blood relatives have had (Including Deceased) Please specify*

[ ] Cancer- _____
[ ] Diabetes- _____
[ ] High Blood Pressure- _____
[ ] Heart Troubles- _____
[ ] Strokes- _____
[ ] Other- _____

When was your last Colonoscopy? _____
Attending Physician: _____
Location: _____

When was your last Endoscopy (EGD)? _____
Attending Physician: _____
Location: _____

Do you use any tobacco products? YES NO
Packs/Day? _____
For how many years? _____
If you quit smoking, when did you quit? _____
How much did you smoke prior to quitting? _____

Do you drink alcoholic beverages? YES NO
How much? Occasional / Moderate / Heavy
For how many years? _____
If you quit drinking alcohol when did you quit? _____
How much did you drink prior to quitting? _____

List below any Operations/Surgeries and any type of Implants you have had in your lifetime *(Including the Year):*

_____

_____

_____

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HIPPA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and disclosers of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law. We also may have these activities performed by other companies on our behalf. Generally, we may access, use, disclose your PHI:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any relates services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be proved to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business operations of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: As required by law, Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings: Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal activity; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosers; Under the law, we must make disclosers to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine out compliance with the requirements of Section 164.500. **Other permitted and required uses and Disclosers** will be made Only with your consent, Authorization or opportunity to object unless required by law. **You may revoke this authorization,** at any time, in writing, except to the extent that your physical or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights Regarding your Protected Health Information

Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI. **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes. You request must state the specific restriction requested and to whom you want the restriction to apply. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically. **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You will then have the right to object or withdraw as provided in this notice.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** If you think we may have violated your privacy rights of if you disagree with a decision we made about access to your PHI, you may file a complaint, anonymously, by calling 1-800-638-5071.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

MEDICAL INFORMATION RELEASE FORM

We are required by law and regulations to protect the privacy of your medical information. Without this form signed by the patient, or and agent given medical power of attorney, your private health information and/or treatments will not be disclosed.

[ ] I authorize the release of medical information including the diagnosis, records, images, examination rendered to me, and claims information. This information may be released to:

[ ] My Primary Care Provider/Or Referring Provider _____

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Parent(s) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Patient Signature _____ Date _____

FINANCIAL POLICY

Thank you for choosing Permian Digestive Disease Center as your health care provider. Our offices are committed to providing the best medical care through communication and understanding. Confirmation and updating of personal address and phone/cell numbers for contact will assure our ability to communicate with you. At any time, you have questions or concerns requiring further information, whether it is medical or business, our staff is available to assist you.

The cost of medical care is determined by the nature and complexity of the illness. There is no "flat rate" for examinations and treatment. **You are given an estimated amount at time of visit before checkout**. After reviewing the Physicians/Providers documentation for the visit additional services/procedures maybe added to the visit.

Out-of-network Insurance Patients will be expected to pay the Out-of-Network Co-Insurance and deductibles at the time services are rendered. Permian Digestive Disease Center will file with your Insurance Company as a courtesy.

Contracted Insurance Patients at each visit, your current insurance card(s) will require presentation when *"signing in"* at the front desk. The Patient will be responsible for any co-pays, deductibles, or non-covered services at the time of the visit. The contracted allowable fees, of the specific contracted insurance, will be considered when payment is requested. Co-pays will not be billed since this is a requirement on your part by your insurance. If the insurance company is unable to process a claim due to inaccurate or missing information from you, you are responsible for the bill.

Non-Insured Patients will be expected to pay in the **full estimated total** at the time of services.

A statement of your unpaid balance plus additional services not covered by insurance will be sent to you for full payment within 90 days. To avoid collection procedures your account must be kept current.

Please sign to acknowledge you agree and understand the policy:

Patient Signature: _____ Date: _____