Wake Forest Endoscopy Center

10540 Ligon Mill Rd., Suite 109
Wake Forest, NC 27587

Effective April 14, 2003, a new federal regulation, known as "HIPAA Privacy Rule," requires that we provide detailed notice in writing of our privacy practices. Attached is a SUMMARY OF NOTICES OF PRIVACY PRACTICES for Wake Forest Endoscopy Center. An authorization instructing our office on how to communicate with you about any healthcare information pertaining to your treatment and billing information is also included. **Please read, complete, and sign all attached authorization according to your preference(s).**

If your appointment is scheduled at Wake Forest Endoscopy Center, please bring all completed HIPAA authorization forms along with your completed registration forms and insurance cards to your appointment. PLEASE DO NOT MAIL REGISTRATION FORMS TO OUR OFFICE.

If your procedure is scheduled at the hospital, only mail the completed/signed HIPAA authorization forms back to our office to the address listed below:

Wake Forest Endoscopy Center
10540 Ligon Mill Rd.
Suite 109
Wake Forest, NC 27587

If your procedure is scheduled at the hospital, please complete the enclosed medical forms for the facility where your procedure is scheduled and take with you on the day of your procedure. Do not mail the hospital forms back to Wake Forest Endoscopy Center, as the hospital will need this paperwork.

Wake Forest Endoscopy Center

10540 Ligon Mill Rd., Suite 109
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Chart # _____ Date _____

I give my permission for the providers of the Wake Forest Endoscopy Center to release ANY information about my medical condition, prescriptions, and financial account to:

Name: _____
Name: _____
Name: _____

Below, I give my, permission for the providers of the Wake Forest Endoscopy Center to release prescriptions and samples ONLY to:

Name: _____
Name: _____
Name: _____

The above mentioned person (s) will be required to provide photo ID when picking up requested items.

Patient name: _____ DOB: _____

Patient signature: _____

By signing on the line below, I acknowledge that 1 was provided access to Privacy Practices of the Wake Forest Endoscopy Center:

Print Name: _____ DOB: _____

Patient Signature: _____

For Personal Representation of the patient (if applicable)
Print Name of Personal Representative: _____
Representative's Relationship (i.e. parent/guardian/other, etc.): _____
Signature of Personal Representative: _____

_____ I refuse to acknowledge I was provided access to the Notice of Privacy Practices of Wake Forest Endoscopy Center:

_____ _____
Signature of Practice Employee Date

Summary of Notice of Privacy Practices

Effective Date: April 14,2003

DESCRIPTION OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. FOR ADDITIONAL INFORMATION, PLEASE REFER TO THE FULL VERSION OF THIS NOTICE OR CONTACT OUR PRIVACY OFFICER.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use or disclose your health information:

- To treat you;
- To get paid for treating you;
- To run the practice;
- To remind of you of appointments; and
- As may be required or otherwise permitted by law.

For more information on how we may use or disclose your health information, please refer to the full version of the Notice or contact out Privacy Officer.

We will use or disclose your health information for other purposes only with your authorization. If you authorize us to disclose your protected health information for other purposes, you may revoke that authorization at any time by notifying us.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have the right to:

- Ask us to limit the information that we share;
- Receive confidential communications from us regarding your health information;
- Look at and obtain a copy a copy of your health information;
- Amend mistakes in your health information;
- Obtain a list of disclosures of your health information that we have made; and
- Obtain a copy of the full version of our Notice of Privacy Practices.

For more information on how to exercise your rights and how such rights may be limited by law, please refer to the full version of this Notice or contact our Privacy Officer.

OUR DUTIES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties with respect to your protected health information and our privacy practices, and to abide by the terms of our Notice of Privacy Practices.

REVISIONS TO NOTICE OF PRIVACY PRACTICES

We may revise our policies with respect to the privacy of patient health information from time to time. Any amendments to our Notices shall be posted in our offices, and copies of any amended Notice will also be available in our offices.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. Foe more information on how to file a complaint, please refer to the full version of this Notice or contact our Privacy Officer.

PRIVACY OFFICER CONTACT INFORMATION

If you have any questions regarding your privacy rights, please refer to the full version of this Notice or contact our office at (919) 554-6253.

Patient Registration

(Please Print)

1. Chart Number _____

2. Patient's Full Name _____ 3. Sex: ❑ M ❑ F
   Last First Middle Name Preferred

4. Race: (please circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined

   Ethnicity: (please circle) Non-Hispanic, Hispanic, Patient Declined Preferred Language _____

5. Patient's Social Security # _____ 6. Date of Birth _____ Age _____

7. Patient's Home Address _____
   Street or Route City State Zip

   Patient's Email Address _____

8. Primary Care Doctor _____ 9. Financial Responsibility: ❑ Patient ❑ Other

10. Referring Doctor _____

11. Patient's Home Phone (___)_____ Patient's Work Phone (___)_____ Patient's Cell Phone (___)_____

    Preferred Notification Method: (please circle) Postal Mail, Phone, Web Message

12. Is the Patient Currently Employed? ❑ Yes ❑ No

    Patient's Employer _____

    Employer's Address _____
    Street or Route City State Zip

13. Patient's Marital Status ❑ S ❑ M ❑ D ❑ W ❑ Sep. Spouse Name _____

14. Person we may contact in case of an emergency: Relationship _____

    Name _____ Telephone # _____

    Address _____
    Street or Route City State Zip

INSURANCE INFORMATION – We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE

15. Insurance Company _____ Address _____

16. Subscriber's Name _____ 17. Subscriber's Sex: ❑ M ❑ F

18. Subscriber's Date of Birth _____ 19. Subscriber's Social Security # _____

20. Patient's Relationship to the Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

21. Subscriber's Employer _____

22. Subscriber's ID # _____ 23. Group # _____

SECONDARY INSURANCE COVERAGE

24. Insurance Company _____ Address _____

25. Subscriber's Name _____ 26. Subscriber's Sex: ❑ M ❑ F

27. Subscriber's Date of Birth _____ 28. Subscriber's Social Security # _____

29. Patient's Relationship to the Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

30. Subscriber's Employer _____

31. Subscriber's ID # _____ Group # _____

OTHER INSURANCE ❑ Yes ❑ No

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT I hereby authorize Wake Forest Endoscopy Center and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ('Patient) such medical care, examination and treatment as may be ordered by a Wake Forest Endoscopy Center physician in his or her medical judgment and such medical care, examination or treatment as is reasonable incident thereto. I herebyauthorize direct payment to Wake Forest Endoscopy Center of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient Is entitled in consideration of services to be rendered by Wake Forest Endoscopy Center to the Patient. I understand that, to the extent permitted by applicable law, l am and I agree hereby to be, financially responsible to Wake Forest Endoscopy Center for charges not covered by this agreement, and I hereby guarantee payment to Wake Forest Endoscopy Center on demand for all such charges.

Signature _____ Please check one: ❑ Patient ❑ Authorized Representative

Date _____ ❑ Parent or Guardian of Minor

AUTHORIZATION TO RELEASE 1NFORMATION: I hereby authorize Wake Forest Endoscopy Center to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by the Wake Forest Endoscopy Center to the Patient. I also hereby authorize the Wake Forest Endoscopy Center to release any medical Information to any licensed physician, health care provider, or medical facility to which the Patient may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Signature _____ Please check one: ❑ Patient ❑ Authorized Representative

Date _____ ❑ Parent or Guardian of Minor