

CENTER FOR GASTROINTESTINAL DISORDERS, Inc.

S. SAEED ZAMANI, M.D.

American Board Certified in gastroenterology and Internal Medicine

112 La Casa Via, Suite 320
Walnut Creek, CA 94598

www.giexcellence.com

Tel.: (925) 939 5599
Fax: (925) 939 4099

Dear patient:

Thank you for selecting us as a medical provider for your healthcare needs. It is our privilege to provide high quality gastroenterology services to you. We would like to take this opportunity to welcome you to our medical office.

Enclosed please find a registration package with forms to complete. You may also download these forms at www.giexcellence.com. Please take the time to fill out these forms completely and accurately and bring them with you on your first appointment or mail them at least 5-7 days prior to your appointment. This helps us to provide more time during your visit to discuss management plans. Please review the Notice of Privacy Practices enclosed in your package and sign acknowledgement section of your health questionnaire.

In order to provide the best quality medical care, we would like to request you to bring any necessary referral letter from your referring physician and any pertinent laboratory or imaging reports (not the disc) performed within the last 3-6 months. You may ask your referring physician to mail or facsimile (Fax) these reports to our office. This will insure our physician to have necessary information to proceed with your care.

Please bring your insurance card and a pictured ID card with you so that we can make a copy from your card. According to insurance industry regulations, we have to collect co-payments at the time of office visits. Checks and cash are accepted at the time of service. Your cooperation in this matter prevents rescheduling your appointment. If you do not have insurance, total payment is expected at the time of service. We regret that we do not accept credit cards.

It is our mission to accommodate all patients. Please cancel your appointment at least 3 days prior to your appointment so that we can accommodate other patients in need of healthcare. Your attention to this matter prevents charges for not showing for your visit. Your insurance company will not cover this charge. Charge for late office cancellation is up to \$100. Charge for cancellation of a scheduled procedure if not cancelled 3 days prior to procedure is at least \$250. We understand emergency situations are out of your control.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of Muir Medical Group IPA and their staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA system and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

Your health and concerns are important to us. We do our best to provide high quality healthcare for you. Please provide a list of questions prior to your visit to utilize your visit efficiently.

We appreciate you for choosing us and welcome you to our practice. If you have any questions or need directions, please do not hesitate to call us at (925) 939 5599. We are looking forward to your visit.

Thank you.

CENTER FOR GASTROINTESTINAL DISORDERS, Inc.

PATIENT INFORMATION REGISTRATION FORM

(Please print clearly)

Patient Name _____ Age ____ DOB _____ Gender ____ Marital Status ____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Social Security # _____ Drivers License _____

Fax Number (you may want results faxed to you) _____ E-Mail: _____

Patient's employer _____ Occupation _____

Work address _____ Work Phone _____

Referring Physician _____ Emergency contact _____ Phone _____

Your Pharmacy: Name and address: _____

Fax: _____ Phone _____

May we leave a message? at your home? Yes on your answering machine? Yes on your cell phone? Yes

PRIMARY INSURANCE INFORMATION

Primary coverage, Name of carrier _____

Subscriber Name _____ DOB _____ relationship to patient _____

ID Number _____ Group Number _____ Effective Date _____

SECONDARY INSURANCE INFORMATION

Secondary coverage, Name of carrier _____

Subscriber Name _____ DOB _____ Relationship to patient _____

ID Number _____ Group Number _____ Effective Date _____

ASSIGNMENT OF BENEFITS

I certify that I, and/or my dependant(s) have insurance coverage as stated above, and assign directly to Center for Gastrointestinal Disorders, Inc. (practice) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance carrier. I authorize the use of my signature on all insurance submissions.

The above named physician/Practice may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payments for the services and determining insurance benefits payable for related services.

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Responsible Party Signature _____ Date _____
 Relation to patient _____ Date _____

PATIENT HISTORY FORM AND INFORMATION

Patient Name	Date of Birth	Age	Gender	Referring Physician
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Reason for appointment

Colon cancer Screening

Have you had any of the following illnesses?

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Pacemaker/internal defibrillator | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Taking Coumadin |
| <input type="checkbox"/> Heart valvular disease (or murmur) | <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema/Chronic bronchitis | <input type="checkbox"/> Kidney disease |

If yes, explain:
 Other disorders:

Prior Surgeries:

Medications taken recently

Drug allergies

- Not known Penicillin Sulfa Morphine Demerol Fentanyl Versed Valium
 Novocain Iodine **LATEX** Others:.....

Social History

Occupation:..... Smoking: Don't smoke Packs per day.....
 Alcoholic beverages: Don't drink Rarely Moderately Illicit drugs:.....

Family History

	Age	Healthy	Major health Issues	Deceased	Cause of death
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Sons	_____	_____	_____	_____	_____
Daughters	_____	_____	_____	_____	_____
Others.....	_____	_____	_____	_____	_____

Any family history of: Colon cancer Colon polyp Crohn's disease/Ulcerative colitis Gastrointestinal cancers
 Other gastrointestinal diseases

CENTER FOR GASTROINTESTINAL DISORDERS, Inc.

Review of Systems

Height _____ Weight _____ lbs.

General

- ___ Weight loss
___ Weight gain
___ Chills
___ Fever

Gastrointestinal (Digestive)

- ___ Poor appetite
___ Trouble swallowing
___ Pain with swallowing
___ Heartburn
___ Regurgitation food
___ Nausea
___ Vomiting
___ Vomiting blood
___ History peptic ulcer disease
___ Bloating
___ Abdominal pain
___ Gallbladder surgery
___ Abdominal surgery
___ Liver disease
___ Hepatitis
___ Blood transfusion
___ Jaundice
___ Pancreatic disease
___ Diarrhea
___ Constipation
___ Black colored stool
___ Diverticulosis
___ History of colon polyp/cancer
___ Blood in stool
___ Mucus in stool
___ Fecal incontinence
___ Anal pain or itching
___ Anal fissure

Respiratory

- ___ Frequent cough
___ Wheezing
___ Asthma
___ Bloody sputum

Cardiovascular

- ___ Chest pain
___ Shortness of breath
___ Heart attack
___ High blood pressure
___ Heart murmur
___ Swelling feet/legs

Musculoskeletal

- ___ Muscle pain
___ Muscle weakness
___ Joint pain
___ Back pain

Genitourinary

- ___ Urinary burning sensation
___ Blood in urine
___ Night time urination

Neuro-Psychiatric

- ___ Depression
___ Anxiety
___ Dizziness
___ Seizures
___ Paralysis

Neck

- ___ Stiffness
___ Enlarged glands

Head, Eyes, ears, Nose, Throat

- ___ Eye disease
___ Headache
___ Ear ache
___ Impaired hearing

Hematological

- ___ Slow to heal after the cuts
___ Anemia
___ Iron deficiency
___ Abnormal bruising
___ History of excessive bleeding after tooth extraction or surgery

Endocrine

- ___ Hormone therapy
___ Hot intolerance
___ Cold intolerance
___ Thyroid disease
___ Diabetes

Gynecological

- ___ Vaginal discharge
___ Abnormal vaginal bleeding
___ Irregular periods
___ Miscarriages
___ No. Pregnancies _____
___ 1st day of last period _____

Skin

- ___ Skin disease
___ Rash, hives, eczema
___ Abnormal pigmentation

Any other symptoms

Signature of the patient.....Date.....

Source (if other than patient)Signature of the person acquiring this information.....

May we leave a message for the results on your voice mail? ___ Yes ___ No

I hereby acknowledge that I received a copy of Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

[] I would like to receive a copy of any amended Notice of Privacy Practices.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

[] Parent or guardian of minor patient [] Guardian or conservator of an incompetent patient

Your pharmacy name and address: _____

Fax: _____ Phone: _____

CENTER FOR GASTROINTESTINAL DISORDERS, Inc.

Notice of Privacy Practices

Center for Gastrointestinal Disorders, Inc.

S. Saeed Zamani, M.D.(Privacy Officer)

112 La Casa Via, Suite 320 Walnut Creek, CA 94598 Phone: (925) 939 5599 Fax: (925) 939 4099

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THE NOTICE, PLEASE CONTACT OUR POLICY OFFICER, S. SAEED ZAMANI, M.D.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. **Sign in sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. **Notification and communication with family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these

CENTER FOR GASTROINTESTINAL DISORDERS, Inc.

disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

8. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

9. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

10. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

11. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

12. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

13. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

14. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

18. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information by mail or phone.

CENTER FOR GASTROINTESTINAL DISORDERS, Inc.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment.

E. Complaints: Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W. Room 509F HHH Building, Washington, DC 20201 You will not be penalized for filing a complaint.

Amendment (August 2010): Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of Muir Medical Group IPA and their staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA system and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

Addendum (September 2013): This Practice prohibits the sale of Protected Health Information (PHI). This practice investigates and informs individuals and authorities of breach of unsecured PHI. It is the right of individuals to restrict disclosure of PHI where individuals paid all fees out of pocket. This practice will respond to your request for electronic copy of PHI.