SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP

PRACTICE LIMITED TO GASTROENTEROLOGY

NOTICE OF PRIVACY PRACTICES

(South Bay Gastroenterology Medical Group) This Notice describes how medical information about you may be used and disclosed and you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.
Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our Contact Person. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time, For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.
Contact Person
If you have any questions, requests, or complaints, please contact:

Privacy Officer
23560 Madison St., Suite 211
Torrance, California 90505
Telephone # (310) 539-2055
Effective Date: April 14, 2003

I_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date:_____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement

_____Date:_____

SOUTH BAY GASTROENTEROLOGY
MEDICAL GROUP
AND
The Endoscopy center of the South Bay Patient History Form

[patient label]

Patient Name_____

Doctors Name:_____

Birthday: _____

Occupation: _____

Marital Status:
Married Divorced Single Widowed

Age _____ Weight _____ Height _____

CHIEF COMPLAINT:

History: **Relation**:

- o Cancer _____
- o Polyps _____
- o Ulcer _____
- o Liver Disease _____
- o Pancreatitis _____

Family History	**If Living**		**If Deceased**	
	Age	Health	Age	Health
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Do you smoke? Yes No
packages per day _____
of years smoked _____

Do you use alcohol? Yes No
drinks per day _____

Illnesses/Surgeries: **Year:**
(if none applicable please indicate with N/A)

Medications: ***List all Medications, Dosage, Frequency and When last taken (this should include all prescription, Herbal and over the counter Medications) If none Applicable please indicate with N/A***
(if necessary please use back of form or attach list)

Allergies: Include Medication, Foods and Latex. Please note reactions. *(if not applicable indicate with N/A)*

Have you ever had a Colonoscopy or Esophagogastroduodenoscopy before? _____

When _____
Results _____

Who is your referring Doctor : _____

Who is your Primary Doctor: _____

Address: _____

_____

Phone: _____

Fax No.: _____

Patient Signature: _____

Date: _____

Patient Name: _____

Name of Doctor: _____

Cardiovascular

Heart Valve Replacement	***Yes*****	***No*****
Chest Pain	Yes	No
Swelling of Ankles	Yes	No
Heart Attacks	Yes	No
High Blood Pressure	Yes	No
Heart Murmur	Yes	No
Defibrillator or Pacemaker	Yes	No
High Cholesterol	Yes	No
Heart Surgery	Yes	No

If yes please explain:

_____

_____

Constitutional

Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No

Diabetes

What Type? _____

Fasting Blood Sugar _____Time_____

Thyroid Trouble	Yes	No

Endocrine

Heat or Cold Intolerance	Yes	No
Excessive Thirst or Urination	Yes	No

Eyes/Skin/ENT

Blurred and double vision	Yes	No
Glaucoma	Yes	No
Rash	Yes	No
Itching	Yes	No
Jaundice	Yes	No
Hearing Loss	Yes	No
Ringing In Ears	Yes	No
Mouth Sores	Yes	No
Nosebleeds	Yes	No

Gastrointestinal

Poor Appetite	Yes	No
Difficulty in Swallowing	Yes	No
Heartburn and Indigestion	Yes	No
Nausea or Vomiting	Yes	No
Bloating	Yes	No
Belching	Yes	No
Regurgitation	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Abdominal Pain	Yes	No
Recent Change In Bowel Habits	Yes	No
Rectal Bleeding	Yes	No
Black, Tarry Stools	Yes	No
Gallbladder Disease	Yes	No
Liver Trouble	Yes	No
Hemorrhoids	Yes	No
Does Food Stick In Throat	Yes	No
Hiatal Hernia	Yes	No

Genitourinary

Burning w/Urination	Yes	No
Blood in Urine	Yes	No
Kidney Trouble	Yes	No

Hematological

Bleeding/Bruising Tendency	Yes	No
Anemia	Yes	No
Past Transfusion	Yes	No

Respiratory

Chronic Cough	Yes	No
Spitting up Blood	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Tuberculosis	Yes	No
Do you use Oxygen?	Yes	No

Infectious Disease

Hepatitis	Yes	No
Type: _____		
AIDS	Yes	No
HIV	Yes	No

Other: _____

Psychiatric

Memory Loss/Confusion	Yes	No
Depression	Yes	No
Panic Attacks	Yes	No

Musculoskeletal

Joint Pain or Swelling	Yes	No
Back Pain	Yes	No
Muscle Pain	Yes	No

Neurological

Headaches	Yes	No
Seizures	Yes	No
Strokes	Yes	No
Difficulty laying on Left Side	Yes	No
Numbness	Yes	No
If yes, where? _____		
Weakness (left or Right)	Yes	No

Are you Pregnant	Yes	No

Reviewed By M.D.

Date: _____ Doctor: _____

Date: _____ Doctor: _____

Reviewed By:

Date: _____ Nurse: _____

Date: _____ Nurse: _____

Nursing Comments:

_____

_____

_____

_____

SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP
AND
THE ENDOSCOPY CENTER OF THE SOUTH BAY

***Please review and complete or initial each item**:*

Consent of Care: I hereby give my consent for treatment of South Bay Gastroenterology Medical Group and Endoscopy Center of the South Bay _____.
(initial)

Authorization to Pay Benefits to Physician: I hereby authorize payment to SBGMG/ECSB for services rendered to me or my dependents. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and /or collection costs and legal fees incurred in an attempt to collect said balance _____.
(initial)

Lifetime Authorization to File Medicare: I request that payment of authorized Medicare benefits be made either to me or on my behalf to SBGMG/ECSB for services furnished me by that provider. I also authorize any holder of medical information about me to release to the Center for Medicare/Medical Services and its agents any information needed to determine these benefits or the benefits payable for related services. _____
(initial)

Patient Valuables: Once you have registered with the front office, you will not need your Picture ID or Insurance Card. Also, please give your family/friend any valuables, i.e., purse, wallet, jewelry, watches, etc… The Endoscopy Center is not responsible for any lost items. _____. (Please check if you have no one to give your belongings to. ___) (initial)

Authorization to Leave Message: I hereby authorize SBGMG/ECSB to leave a message regarding pending appointments or tests at my residence ___Yes ___ No. It is okay to leave a message with my employer, ____Yes ____ No. On my cell phone ____ Yes ____No. It is okay to leave a message with any of my family members listed below:

Family Member : _____ Relationship: _____ Phone #: _____
Family Member : _____ Relationship: _____ Phone #: _____
Family Member : _____ Relationship: _____ Phone #: _____

Social Security No. ☐☐☐ ☐☐ ☐☐☐☐

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ **Date of Procedure** ☐☐ / ☐☐ / ☐☐☐☐

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
Or Ethnicity ☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Sex: ☐ MALE ☐ FEMALE

Print Patient Name: _____

Patient, Parent or Guardian_____ Date: _____
(signature)

SOUTH BAY GASTROENTEROLOGY MEDICAL GROUP
The Endoscopy Center of the South Bay

Please check which doctor you are seeing

- ☐ **Susanna M. Chan, M.D.**
- ☐ **Jerome Cohen, M.D.**
- ☐ **Tonny M. Lee, M.D.**
- ☐ **Norman Panitch, M.D.**

PRACTICE LIMITED TO GASTROENTEROLOGY
23600 Telo Avenue, Suite 260
Torrance, California 90505
Telephone # (310) 539-2055
southbaygastro.com

- ☐ **Edward Piken, M.D.**
- ☐ **Howard Resin, M.D.**
- ☐ **Gloria Sze, M.D.**
- ☐ **Oren Zaidel, M.D.**

PATIENT INFORMATION REQUEST

LAB_____

PATIENT NAME _____ AGE _____ BIRTHDATE _____ SEX ____

NICKNAME _____

EMAIL ADDRESS _____

HOME ADDRESS _____ CITY _____ ZIP CODE _____

MAILING ADDRESS _____ CITY _____ZIP CODE _____

HOME PHONE _____ MARITAL STATUS _____ DRIVER'S LICENSE_____

CELL PHONE _____

YOUR EMPLOYER _____ WORK PHONE_____

ADDRESS _____ CITY_____ ZIP CODE_____

OCCUPATION _____ SOCIAL SECURITY # _____

NAME OF SPOUSE OR PARENT_____ BIRTHDATE _____

SOCIAL SECURITY # _____

EMPLOYER_____ PHONE # _____

PHARMACY NAME _____PHARMACY PHONE #_____

PHARMACY ADDRESS _____

NAME OF EMERGENCY CONTACT _____

RELATIONSHIP_____ ADDRESS _____ PHONE#_____

NAME OF PHYSICIAN WHO REFERRED YOU TO OUR OFFICE _____

NAME OF DENTIST_____ PHONE#_____

INSURANCE INFORMATION:

DOES YOUR INSURANCE REQUIRE PRE-AUTHORIZATION? YES ☐ NO ☐ DO YOU HAVE MEDI-CAL? YES ☐ NO ☐

PRIMARY INSURANCE _____ EFFECTIVE DATE _____

SUBSCRIBER _____ ID #_____ GROUP #_____

PATIENT RELATIONSHIP_____

SECONDARY INSURANCE_____ EFFECTIVE DATE _____

SUBSCRIBER _____ ID #_____ GROUP# _____

PATIENT RELATIONSHIP_____

_____ Signature of Patient

_____ Date

REORDER # 99-16795