Please fill out this form and bring it to your appointment.
When printing, select 'fit' or 'fit to page' so all information prints on the page.

PATIENT DATA
FORM MUST BE COMPLETED IN FULL

Today's Date _____

Name _____ Date of Birth _____

Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced Gender ❑ Male ❑ Female

Mailing Address _____
Street City State Zip

Phone Numbers Home _____ Cell _____ Work _____

Primary Phone is ❑ Home ❑ Cell ❑ Work Email Address _____

Preferred Language ❑ English ❑ Arabic ❑ Chinese ❑ French ❑ Hindi ❑ Portuguese ❑ Russian
❑ Spanish ❑ Vietnamese ❑ Unknown ❑ Declined ❑ Other _____

Race ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander
❑ White ❑ Other Race ❑ Unknown ❑ Declined

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Declined

EMPLOYMENT

Employer _____ Dept. | Title _____

Employer's Address _____
Street City State Zip

Referred to Circle City Gastroenterology by _____

Address _____
Street City State Zip Phone

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you

Name & Relationship _____ Daytime Phone _____

Nearest relative or friend not living with you

Name & Relationship _____ Daytime Phone _____

INSURANCE INFORMATION

Primary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

Secondary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

Tertiary _____ Policy # _____ Group # _____

Name of Insured & Relationship _____ DOB _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____
Street City State Zip

I authorize CCGI to communicate electronically with my preferred pharmacy to obtain my prescription history. ❑ Yes ❑ No

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of CCGI and its affiliates. I authorize payment of medical benefits to CCGI and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient / Guarantor Signature* _____ Date _____

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

Please fill out this form and bring it to your appointment.
When printing, select 'fit' or 'fit to page' so all information prints on the page.

PERSONAL HISTORY

Today's Date _____

Name _____ Age _____ Date of Birth _____

Referred by _____ Primary Care Physician _____

Other physicians involved in your healthcare _____

Describe the reason(s) for your visit _____

1) PATIENT MEDICAL HISTORY Check all that apply.

- ❑ **Cirrhosis**
- ❑ **Colon Cancer**
- ❑ **Colon Polyps**
- ❑ **Crohn's Disease**
- ❑ **Diverticulitis**
- ❑ **Diverticulosis**
- ❑ **End Stage Renal Disease (ESRD)**
- ❑ **GERD**
- ❑ **Hepatitis B**
- ❑ **Hepatitis C (HCV)**
- ❑ **Hiatal Hernia**
- ❑ **Irritable Bowel Syndrome**
- ❑ **Liver Disease**
- ❑ **Stomach/Intestinal Ulcers**
- ❑ **Ulcerative Colitis**
- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Arthritis/Osteoarthritis
- ❑ Asthma
- ❑ Cancer: Type _____
- ❑ Cataracts
- ❑ Chronic Kidney Disease (CKD)
- ❑ Congestive Heart Disease (CHF)
- ❑ COPD/Emphysema
- ❑ Coronary Artery Disease (CAD)
- ❑ Diabetes
- ❑ Glaucoma
- ❑ HIV/AIDS
- ❑ Hyperlipidemia/High Cholesterol (HLD)
- ❑ Hypertension
- ❑ Hypothyroidism
- ❑ Migraines
- ❑ Myocardial Infarction/ Heart Attack
- ❑ Nerve/Muscle Disease
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pancreatitis
- ❑ Seizures
- ❑ Stroke (CVA)

❑ Other _____

3) VACCINES

Have you ever had a Pneumococcal (Pneumonia) Vaccine? ❑ Yes ❑ No

Have you ever had any of the following vaccines? ❑ Influenza (Flu) ❑ Hepatitis A ❑ Hepatitis B

❑ Other _____

4) SURGICAL HISTORY

Check all that apply and provide dates.

- ❑ **Colon Surgery** _____
- ❑ **Colonoscopy** _____
- ❑ **Hemorrhoid Surgery** _____
- ❑ **Gallbladder Surgery** _____
- ❑ **Gastric Surgery** _____
- ❑ **Heller Myotomy** _____
- ❑ **Liver Surgery** _____
- ❑ **Nissen Fundoplication** _____
- ❑ **Small Intestine Surgery** _____
- ❑ **Upper Endoscopy (EGD)** _____
- ❑ Appendectomy _____
- ❑ Brain Surgery _____
- ❑ Breast Surgery _____
- ❑ C-Section _____
- ❑ CABG/Heart Surgery _____
- ❑ Cosmetic Surgery _____
- ❑ Defibrillator _____
- ❑ Fracture Surgery _____
- ❑ Hernia Surgery _____
- ❑ Hysterectomy
  - Abdominal _____
  - Vaginal _____
- ❑ Joint Replacement _____
- ❑ Laparotomy _____
- ❑ Obesity Surgery _____
  - Type, if known _____
- ❑ Pacemaker _____
- ❑ Prostate Surgery _____
- ❑ Spinal Surgery _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Transplant Surgery _____
- ❑ Tubal Ligation _____
- ❑ Valve Replacement Surgery _____
- ❑ Vasectomy _____
- ❑ Other _____

Name _____ Date of Birth _____

5) MEDICATIONS

List Current Medications (including herbal) and Dosage

_____

_____

_____

_____

_____

List Current Medications (including herbal) and Dosage

_____

_____

_____

_____

_____

Are you currently taking any blood thinners? ❑ Coumadin ❑ Plavix ❑ Warfarin ❑ Xarelto ❑ Other _____

Are you currently taking any of the following aspirin/NSAIDs? ❑ Advil ❑ Aleve ❑ BC Powder ❑ Goody's Powder ❑ Ibuprofen ❑ Naprosyn

6) ALLERGIES

List any medication allergies. ❑ No known medication allergies

_____

List any enviromnental or food allergies. ❑ No known enviromnental allergies ❑ No known food allergies

_____

7) FAMILY HISTORY (1ST degree relatives) Check all that apply.

	Mother	Father	Sister	Brother	Son	Daughter	Age at diagnosis (if known)
Acid Reflux/GERD	❑	❑	❑	❑	❑	❑	_____
Barrett's Esophagus	❑	❑	❑	❑	❑	❑	_____
Colon Polyps	❑	❑	❑	❑	❑	❑	_____
Crohn's Disease	❑	❑	❑	❑	❑	❑	_____
Ulcerative Colitis	❑	❑	❑	❑	❑	❑	_____
Cancers							
Breast	❑	❑	❑	❑	❑	❑	_____
Colon	❑	❑	❑	❑	❑	❑	_____
Esophagus	❑	❑	❑	❑	❑	❑	_____
Lung	❑	❑	❑	❑	❑	❑	_____
Lynch Specific (uterine, bladder or ureter)	❑	❑	❑	❑	❑	❑	_____
Pancreas	❑	❑	❑	❑	❑	❑	_____
Prostate		❑		❑	❑		_____
Stomach	❑	❑	❑	❑	❑	❑	_____
Other _____	❑	❑	❑	❑	❑	❑	_____
Liver Disease	❑	❑	❑	❑	❑	❑	_____
Hyperlipidemia/High Cholesterol (HLD)	❑	❑	❑	❑	❑	❑	_____
Diabetes	❑	❑	❑	❑	❑	❑	_____
Heart Disease/Coronary Artery Disease	❑	❑	❑	❑	❑	❑	_____

8) SOCIAL HISTORY

Provide details regarding current and/or past use of the following:

Alcohol (beer, wine, liquor) ❑ Yes ❑ No Usage _____

I.V. or Recreational Drugs ❑ Yes ❑ No Usage _____

Tobacco (cigarettes, cigars, chewing tobacco) ❑ Yes ❑ No Usage _____

Smoking Status ❑ Every Day ❑ Some Days ❑ Former ❑ Never ❑ Current Status Unknown ❑ Unknown if Ever Smoked

Name _____ Date of Birth _____

9) SYSTEMS REVIEW

Do you have or have you experienced any of the following in the last 12 months?

CONSTITUTIONAL
- ❑ Body Aches
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Loss of Appetite
- ❑ Malaise (feeling ill)
- ❑ Night Sweats
- ❑ Weight Gain
- ❑ Weight Loss (dieting)
- ❑ None of the Above

EYES
- ❑ Blurred Vision
- ❑ Visual Changes
- ❑ None of the Above

EARS/NOSE/THROAT
- ❑ Ear Pain/Ringing
- ❑ Hearing Loss
- ❑ Mouth Ulcers/Sores
- ❑ Nose Bleeds
- ❑ Problems with Gums/Teeth
- ❑ Trouble Swallowing
- ❑ None of the Above

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Leaky Heart Valves
- ❑ Heart Murmur
- ❑ Heart Racing/Skipping
- ❑ High Blood Pressure
- ❑ Palpitations
- ❑ None of the Above

RESPIRATORY
- ❑ Chronic Cough
- ❑ Shortness of Breath
- ❑ Wheezing or Asthma Symptoms
- ❑ None of the Above

GASTROINTESTINAL
- ❑ Abdominal Pain/Discomfort
- ❑ Anal/Rectal Pain or Itching
- ❑ Anal Spasm
- ❑ Black Stool
- ❑ Bloating/Belching/Gaseousness
- ❑ Change of Bowel Habit
- ❑ Constipation
- ❑ Diarrhea/Loose Stool
- ❑ Difficulty in Swallowing
- ❑ Heartburn/Esophageal Reflux
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Mucus in Stool
- ❑ Nausea/Vomiting
- ❑ Rectal Bleeding (in stool, commode, toilet paper)
- ❑ Unintentional Weight Loss (not dieting)
- ❑ None of the Above

GENITOURINARY
- ❑ Are you pregnant?
- ❑ Date of last period _____
- ❑ Blood in Urine
- ❑ Burning/Pain with Urination
- ❑ Increased Frequency/During Night
- ❑ Recent/Frequent Urinary Tract Infection
- ❑ Kidney Stones
- ❑ None of the Above

SKIN
- ❑ Itching/Dry Skin
- ❑ Jaundice (yellow eyes or skin)
- ❑ Rashes, Bumps or Sores
- ❑ None of the Above

NEUROLOGIC
- ❑ Headaches
- ❑ Dizziness/Vertigo
- ❑ Head Trauma/Injury
- ❑ Recent Numbness/Weakness
- ❑ Seizures
- ❑ None of the Above

MUSCULOSKELETAL
- ❑ Back Pain
- ❑ Decreased Range of Motion
- ❑ Joint Pain/Arthritis
- ❑ Problems Walking/Calf or Leg Pain
- ❑ None of the Above

ENDOCRINE
- ❑ Bruise easily
- ❑ Excessive Thirst
- ❑ Heat/Cold Intolerance
- ❑ History of High or Low Blood Sugar
- ❑ None of the Above

PSYCHIATRY
- ❑ Anxiety
- ❑ Changes in Sleep Pattern
- ❑ Depression
- ❑ Loss of memory
- ❑ None of the Above

HEMATOLOGY/LYMPHATIC
- ❑ Bleeding Problems
- ❑ Enlarged Nodes/Swollen Glands
- ❑ Excessive Bruising
- ❑ History of Anemia
- ❑ None of the Above

ALLERGY/IMMUNOLOGY
- ❑ Seasonal Allergies
- ❑ None of the Above

OTHER _____

_____

_____

_____

_____

Patient Signature _____ Date _____

My signature below confirms I have reviewed the above with the patient/family.

Physician Signature _____ Date _____

Please fill out this form and bring it to your appointment.
When printing, select 'fit' or 'fit to page' so all information prints on the page.

HEPATITIS C SCREENING QUESTIONNAIRE

Patient Name _____ Date of Birth _____

The hepatitis C virus (HCV) is spread through exposure to contaminated blood. This can occur by sharing drug needles, through accidental needle sticks, or from mother to child during pregnancy. In many cases, HCV has no symptoms until significant liver damage has occurred. Therefore, early detection is key to treating this virus effectively. The CDC recommends that patients who meet the below criteria complete a rapid screening test for HCV. Please answer the questions below to determine if you are a candidate for this test. Note: If you have previously been tested for HCV by any physician, your insurance carrier may not cover this test.

❑ Yes ❑ No Have you previously been tested for hepatitis C by your primary care physician or any other provider?

If yes, no need to proceed with questionnaire.
If no, please answer the following 10 questions:

1. ❑ Yes ❑ No Were you born between 1945 through 1965?
2. ❑ Yes ❑ No Are you currently or have you ever used recreational injectable and/or IV drugs?
3. ❑ Yes ❑ No Have you ever received a transfusion of plasma products (clotting factor concentrates) produced before 1987?
4. ❑ Yes ❑ No Are you currently or were you ever on long-term hemodialysis?
5. ❑ Yes ❑ No Do you have a history of persistently abnormal alanine aminotransferase levels (ALT-liver function blood test)?
6. ❑ Yes ❑ No Have you ever been diagnosed with HIV?
7. ❑ Yes ❑ No Did you receive a transfusion of blood, blood components, or an organ transplant before July 1992?
8. ❑ Yes ❑ No Are you a healthcare, emergency medical, or public safety worker who has ever had exposure to HCV-positive blood? (e.g. accidental needle stick, sharps, or mucosal exposure)
9. ❑ Yes ❑ No Are you a biological child of a HCV-positive woman?
10. ❑ Yes ❑ No Have you been exposed to HCV within the past 6 months?

Patient Signature _____ Date _____

Staff Use Only

If patient answers yes to any of the above questions and accepts screening, administer Rapid Hepatitis C test.

❑ Patient meets criteria; test administered.
❑ Patient does not meet criteria; test not administered.
❑ Patient meets criteria; patient declined screening.
❑ Patient does not meet criteria; patient desires screening.

Rapid Hepatitis C Results ❑ Positive ❑ Negative Lot # _____ Exp. Date _____

Notes _____

_____

MA Name _____ MA Signature _____

Physician Signature _____ Date _____

Please fill out this form and bring it to your appointment.
When printing, select 'fit' or 'fit to page' so all information prints on the page.

FINANCIAL DISCLOSURE STATEMENT

Date _____

Patient Name _____ Date of Birth _____
(please print)

Thank you for choosing CCGI. Please read and sign this Financial Disclosure Statement prior to your appointment. Patients who do not pay in full at the time of service must complete the required information and insurance forms before service will be rendered.

You can expect to receive the following bills as a result of your visit:

- **Physician Fee:** Fee to be paid to the physician for performing the service. This bill will be from CCGI.
- **Lab Fee:** If a lab test is ordered, a second bill will come from a lab or a radiologist.

Some insurance companies require pre-certification for this service. We will make every effort to verify your benefits and obtainany necessary pre-certification prior to your appointment. This is not a guarantee of payment.

Your insurance company will send you an Explanation of Benefits that will explain how your bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand your insurance benefits.

Some insurance plans require you to pay different out-of-pocket amounts based on the location where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. We will submit primary, secondary and tertiary claims on your behalf as long as the information needed to process the claim is obtained and verified before your visit. If this information is obtained after your visit or if the information provided is deemed inactive for your dates of service, the patient or guarantor is responsible for the balance.

We accept cash, checks and major credit cards. CCGI collects co-payments at the time of service.

PATIENT'S REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices of CCGI and its affiliates and that I may receive multiple bills related to my service as explained above. I authorize payment of medical benefits to CCGI and its affiliates and authorize them to release any medical information necessary to process claims. I give CCGI permission to apply payments received to balances due at CCGI, and understand that payments will be applied to the oldest balance first. I understand that I am financially responsible for any co-payments, deductibles, co-insuranceand non-covered services as outlined by my health plan.

_____ Date _____

*Patient /Authorized Representative Signature ** If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

_____ Date _____

Witness

NOTICE OF PRIVACY PRACTICES

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.

CCGI presents this Notice of Privacy Practices ("Notice") to our patients describing how your identifiable medical information (called protected health information or PHI) may be used or disclosed, and to notify you of your rights regarding this information.

Patient Protected Health Information

Under Federal law, your patient health information is protected and confidential. Protected health information (PHI) 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 Protected Health Information

CCGI uses health information about you for treatment, analyzing procedures and lab results. We also use PHI to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances where the law applies, we may be required to use or disclose the information without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: CCGI will use and disclose your PHI to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your medical record and use it to determine the most appropriate course of care. CCGI may also disclose this information by fax, in person, or via telecommunication. We may communicate to other health care providers who are participating in your treatment, to pharmacists who are filling and refilling your prescriptions, and to family members who are helping with your care.

Payment: CCGI will use and disclose your PHI for payment purposes. For example, CCGI may need to obtain authorization from your insurance company before providing certain types of treatment. CCGI will submit bills and maintain records of payments from your health plan.

Health Care Operations: CCGI will use and disclose your health information to conduct our standard internal operations. Examples include proper administration of records, evaluation of the quality of treatment, and assessing the care and outcomes of your case and others like it.

Release of Information to Family or Friends

CCGI knows that family or friends are an integral part of a patient's care. If you wish to authorize a family member or friend to receive or request information regarding your care or test results, please provide their name and contact information on the
'Notice of Privacy Practices Acknowledgement' form. CCGI will not release your information to any friend or family without your written consent. If you wish to change or update the authorized individuals, you will need to make these updates in writing.

Special Uses

CCGI may use your information to contact you with appointment reminders by phone, mail, email, or text message. CCGI may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. This communication may be sent to you via phone, mail, or email. If you have granted written permission,protected health information may also be sent to you via email. If you wish to authorize the use of email as a method for CCGI to communicate with you regarding your PHI, sign the proper section on the 'Notice of Privacy Practices Acknowledgement' form.

Other Uses and Disclosures Not Requiring Written Permission

CCGI may use or disclose your protected health information for other reasons, even without your consent. Subject to certainrequirements, CCGI is permitted to give out health information without your permission for the following purposes:

•Required by Law

CCGI may be required by the law to disclose your PHI for certain purposes, such as reporting gunshot wounds,suspected abuse or neglect, or similar injuries and events.

- **Research**
  CCGI may use or disclose information for approved medical research subject to specific criteria.

- **Public Health Activities**
  As required by law, CCGI may disclose vital statistics, diseases, proof of immunization, information related to recalls of dangerous products, and similar information to public health authorities.

- **Health Oversight**
  CCGI may be required to disclose information to assist in investigations and audits; eligibility for government programs; inspections; licensure or disciplinary actions; compliance to civil rights laws; and similar activities.

- **Judicial and Administrative Proceedings**
  CCGI may disclose information in response to an appropriate subpoena or court order.

- **Law Enforcement Purposes**
  Subject to certain restrictions, CCGI 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**
  CCGI 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, CCGI may release information as required by military command authorities. CCGI may also disclose information to correctional institutions or for national security purposes.

- **Workers' Compensation**
  CCGI may release information about you as authorized by and to the extent necessary to comply with laws relating to 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. Submit any concerns in writing to CCGI's Compliance Officer (see below).

- **Request Restrictions**
  You may request restrictions on certain uses and disclosures of your health information. These requests must be in writing. CCGI is not required to agree to most restrictions, but if we do agree, CCGI must abide by those restrictions.

- **Restrict Disclosure to a Health Plan**
  You may request, in writing, to restrict disclosure of your PHI to a health plan. For example, you may request in writing that you choose not to use your insurance for a specific visit. If the request is made in writing in advance, the healthcare service or item is paid in full at the time of service, and the disclosure is for payment or healthcare operations, CCGI must agree to the restriction except for cases where the disclosure is required by law. (i.e., your health plan requires all healthcare services to be disclosed or filed.)

- **Confidential Communications**
  You may ask us to communicate with you confidentially including by reasonable alternate means or locations. This request must be made in writing. There may be conditions placed on accommodating the request in certain situations.

- **Inspect and Obtain Copies**
  You have the right to see or receive a copy of your health information. There may be a small charge dictated by California Law for these copies. You may obtain a copy of your health information by completing and submitting a medical records release form. By law, you must receive the requested information within 30 days.

- **Amend Information**
  If you believe information in your record is incorrect, you have the right to request that CCGI correct or amend the existing information. The request must be made in writing and include a reason to support the requested amendment. Your CCGI physician has the right to refuse your request.Regardless, a letter concerning your request will be sent within 60 days of said request.

- **Accounting of Disclosures**
  You may request a list of instances where we have disclosed health information about you within the last six years for reasons other than treatment, payment, or health care operations. This request must be submitted in writing. The request must be fulfilled within 60 days. If CCGI is unable to fulfill the request within 60 days, the law grants a one-time 30 day extension. A written statement regarding the reason for the delay will be provided to you. If you request an accounting more than once in a 12 month period, CCGI may impose a reasonable cost-based fee for each subsequent request.

- **Obtain Paper Copy of Notice**
  If you have previously received this Notice in electronic form, you have the right to request a paper copy of this Notice.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We are also required by law to notify you in the event of a breach of your unsecured PHI.

Please fill out this form and bring it to your appointment.
When printing, select 'fit' or 'fit to page' so all information prints on the page.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT

I, _____ , hereby acknowledge that CCGI and its affiliates have given me the opportunity to read a detailed notice of their Privacy Practices.

_____ Date _____

Patient/Authorized Representative Signature ** If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

If not signed, please provide a reason why the acknowledgement was not obtained.

_____

_____ Date _____

Witness / Staff Signature

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from CCGI and its affiliates to share information regarding care or tests results with the individuals listed below. These individuals may also request protected health information on my behalf.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Is it OK to leave results or protected health information on your voicemail? ❑ Yes ❑ No

I recognize that CCGI and its affiliates may share my protected health information with other healthcare providers, including sensitive health information such as: HIV/AIDS information, substance abuse records, genetic testing information, and developmental disability records. This information may be shared with other healthcare providers via various methods, including but not limited to, fax or health information exchange.

NOTE: If you choose to opt out of having your information shared via health information exchange, you must request and complete an Opt-Out Form available at CCGI offices.

_____ Date _____

Patient/Authorized Representative Signature ** If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

CONSENT TO CORRESPOND ELECTRONICALLY

While CCGI and its affiliates take reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with an CCGI physician regarding medical care, the CCGI physician and/or
his/her representative has my permission to correspond via that email address.

I give permission for an CCGI physician or clinical staff member to email me at _____ @ _____ regarding medical care.

_____ Date _____

Patient/Authorized Representative Signature ** If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*