MID-VALLEY
GASTROENTEROLOGY
Specialists in Digestive Health

Ph: (541) 768-6119 www.midvalleygi.com

Please return all 4 forms completed and signed.

Patient Information

Name:_____ (First Middle Last)

Address:_____

City, State, Zip:_____

Preferred Phone:_____ [ ]Home [ ]Mobile [ ]Work [ ]Message

Alt Phone:_____ [ ]Home [ ]Mobile [ ]Work [ ]Message

Alt Phone:_____ [ ]Home [ ]Mobile [ ]Work [ ]Message

E-mail:_____

Date of Birth:_____ Age:_____

Social Security #:_____ Sex: [ ]M [ ]F

Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed [ ]Other

Preferred Language:_____

Race:_____

Ethnicity: [ ]Hispanic or Latino [ ]Non-Hispanic or Latino [ ]Other or UND

Referring Physician:_____

Primary Care Physician:_____

Employment Information

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Employer's Name:_____

Employer's Phone:_____

Occupation:_____

Emergency Contact

Name:_____

Relationship:_____

Phone:_____

Responsible Party [ ]Same as Patient

Name:_____

Address:_____

City, State, Zip:_____

Employer:_____

Phone:_____

Date of Birth:_____

Social Security #:_____

Primary Insurance

Insurance Company Name:_____

ID #:_____ Group/Policy#:_____

Subscriber's Name:_____

Subscriber's Phone #:_____

Relationship to Patient:_____

Subscriber's Employer:_____

Subscriber's SSN:_____

Subscriber's DOB:_____

Secondary Insurance

:_____

:_____ :_____

:_____

:_____

:_____

:_____

:_____

:_____

*Is this a work related injury? Y / N If yes: Claim #_____

Insurance Authorization and Assignment

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to release information necessary to secure payment. ***I understand that I am responsible for any amount not paid for by my insurance.***

Signature_____ ***Date***_____

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Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect the genetic privacy of individuals. These laws give you the right to decline to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a special team reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants.

In anonymous research, personal information that could be used to identify you, like your name or medical record number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, **simply complete the patient information portion at the bottom of this form**. If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

If you want to decline to have your health information and biological sample available for anonymous or coded genetic research, **check the box below and complete the patient information portion at the bottom.** Your decision is effective on the date your health care provider receives this form.

If you have any questions or concerns about this notice, please contact the Practice Administrator at (541) 768-6119.

No matter what you decide now, you can always change your mind later. If you change your mind, tell your health care provider your decision in writing by sending a letter to Mid-Valley Gastroenterology, Attention: Practice Administrator, 3521 NW Samaritan Drive, Suite 101, Corvallis, OR 97330. If you change your mind, the new decision will apply only to health information or biological samples collected after your health care provider receives written notice of your new decision.

☐ **By checking this box I indicate that I decline** to have my health information and biological samples available for anonymous or coded genetic research.

Printed Name Date of Birth Signature

NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGMENT

THIS NOTICE DESCRIBES YOUR REFERRAL RIGHTS WHEN YOUR HEALTH CARE PROVIDER REFERS YOU TO ANOTHER PROVIDER OR FACILITY FOR ADDITIONAL TESTING OR HEALTH CARE SERVICES.

In accordance with Oregon law, when we refer you for care outside of our clinic, we are required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law says (ORS 441.098):

- A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.

- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient.

- The oral or written notice of patient choice shall clearly inform the patient:
  a) That when referred, a patient has a choice about where to receive services; and
  b) Where the patient can access more information about patient choice.

- The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;

- If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.

- A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.

By signing below, I acknowledge that I <u>have read and understand my referral rights as outlined above.</u>

_____ _____
Patient Signature Date

_____
Print Patient Name

-OR-

_____ _____
Parent, Guardian, Responsible Party, Legal Representative Signature Date

_____
Description of Representative's Authority

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FINANCIAL POLICY

Mid-Valley Gastroenterology is committed to serving your healthcare needs. Part of this commitment is providing a clear outline of our financial policy.

Financial Responsibility
You are ultimately responsible for payment of medical services you receive. All patients must complete our patient information forms, provide photo ID, and a valid insurance card.

Procedures
Your bill from Mid-Valley Gastroenterology represents the physician charges only. You will receive a separate bill from other entities involved in your care, including, but not limited to, facility, anesthesia and pathology.

Screening vs. Diagnostic Colonoscopy
Colonoscopy coverage varies with each insurance plan. It is important to understand that if you are referred for a screening colonoscopy with a personal history of precancerous polyps or report symptoms, you will not receive a screening benefit through your insurance. Your medical benefits will apply. We cannot change a diagnosis for the purpose of securing reimbursement from any insurance carrier.

Insurance and Copays
You are required to provide our office with accurate insurance information. All copays and past due balances are due before your scheduled visit. Failure to clear any past due balance may result in the cancellation of your appointment. As a courtesy, we will bill most primary and secondary insurance. You are responsible for any amounts not covered by your insurance, including deductible, copay, coinsurance, and services that are not covered by your plan. Coverage for medical services depends on your individual policy. It is your responsibility to verify coverage.

Uninsured / Self Pay
If an insurance plan will not be billed, an estimate will be provided to you. For office visits, we require a minimum deposit of $200 for new patients and $100 for established patients. Payment for procedure(s) scheduled will be based on non-intervention. If any intervention is performed, additional charges may apply. Deposit amounts are required prior to service. Any additional charges will be due within 30 days following your visit/procedure.

Missed/Cancelled Appointments
We require 24-hour notice for canceling or rescheduling your office visit and 5 business days for canceling or rescheduling your procedure. After 3 missed or late-cancel appointments, you will be asked to return to your Primary Care Physician.

Returned Check
Any checks returned by your financial institution will be assessed a $20 fee.

Completion of Forms
In some situations, it may be appropriate for our practitioners to complete forms, such as FMLA, disability, etc. In this case, you must complete the patient section, and a separate "Authorization to Disclose Health Information" is required. You will be responsible for any charge associated with completing these forms.

Please contact our Patient Accounts office at (541) 768-7600 with any questions you may have or visit our website at www.midvalleygi.com.

Patient Financial Agreement

I have read and acknowledge the above stated financial policy and agree to full responsibility of all incurred costs.

_____ _____
Signature of Responsible Party **Date**

_____
Printed Name

*** _____***I acknowledge that the Notice of Privacy Practices has been made available to me.***
(Initials)

*** _____***I acknowledge that the Nondiscrimination Notice has been made available to me.***
(Initials)

NOTICE OF PRIVACY PRACTICES
for Corvallis Gastroenterology, P.C. dba
MID-VALLEY GASTROENTEROLOGY

Revision Date: September 27, 2019

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 this notice, please contact the Privacy Officer of our office at (541) 768-6119.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practices and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

YOUR MEDICAL INFORMATION. We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other physicians or healthcare providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. "Use" is what we do with your information in this office. "Disclose" means sharing your information with others outside this office. All of our permitted uses and disclosures of information fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in your care.
- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations**. We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
- **Health Information Exchange**. We may share your medical information with other health care providers or other health care entities through a health information exchange for the purpose of providing faster access to information and better coordination of care.
- **To the Department of Health and Human Services (HHS)**. We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review, or enforcement action.
- **To You**. We must disclose your medical information to you when you request it as described below. We may disclose your medical information to you in other situations.
- **Opportunity to Agree or Object**. We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider's professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition.
- **For Appointment Reminders**. We may use medical information about you to remind you about appointments using phone calls, emails, or text messages. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.
- **Incidental Use**. Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.
- **Valid Authorization**. We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- **Public Interest and Benefit Activities**. We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order; for public health activities, such as providing immunization records to a school with a parent's permission; to government agencies regarding victims of abuse; to health oversight agencies to carry out legally authorized audits and investigations; pursuant to court orders and subpoenas that meet certain requirements; to law enforcement as described below; to a coroner or medical examiner; as necessary to facilitate organ or tissue donation and transplantation; for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions; and for workers' compensation or similar programs.
- **Law Enforcement**. We may disclose your health information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Limited Data Set**. In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.

DISCLOSURES THAT REQUIRE AUTHORIZATION FROM YOU.

● **Psychotherapy Notes, Marketing, and Sales of Protected Health Information**. Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.

● **Other**. Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

● **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you may be required to submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

● **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office.

To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

● **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

● **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

● **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

● **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.

● **Right to Receive Notice of Breach**. You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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MID-VALLEY GASTROENTEROLOGY NONDISCRIMINATION POLICY

Corvallis Gastroenterology, PC dba Mid-Valley Gastroenterology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Mid-Valley Gastroenterology does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Mid-Valley Gastroenterology:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Mid-Valley Gastroenterology at (541) 768-6119

If you believe that Mid-Valley Gastroenterology has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Practice Manager, 3521 NW Samaritan Drive, Suite 101, Corvallis, OR 97330, (541) 768-6119, Fax: (541) 768-6120. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance the Practice Manager is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-541-768-6119 (TTY: 1-541-768-6119).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-541-768-6119 (TTY: 1-541-768-6119).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-541-768-6119（TTY：1-541-768-6119).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-541-768-6119 (телетайп: 1-541-768-6119).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-541-768-6119 (TTY: 1-541-768-6119)번으로 전화해 주십시오.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-541-768-6119（TTY:1-541-768-6119）まで、お電話にてご連絡ください.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-145-867-9116 (رقم هاتف الصم والبكم: (1-145-867-9116)

Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-541-768-6119 (TTY: 1-541-768-6119).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-541-768-6119 (телетайп: 1-541-768-6119).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-541-768-6119 (TTY: 1-541-768-6119).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-541-768-6119 (ATS : 1-541-768-6119).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-541-768-6119 (TTY: 1-541-768-6119).

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-541-768-6119(TTY: 1-541-768-6119) تماس بگیرید.

Cambodian:

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-541-768-6119 (TTY: 1-541-768-6119)។

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-541-768-6119 (TTY: 1-541-768-6119).