Colorectal Health Northwest

Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225
Office 503.216.5380
Fax 503.216.5399
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS
Megan M. Cavanaugh, MD, FACS, FASCRS
Amanda M. McClure, MD
Colon and Rectal Surgeons

HEALTH QUESTIONNAIRE

Patient Name: _____Date of Birth: ___/____/_____**Age**: ____ Date of Visit: _____

What is your marital status? ☐ Single ☐Married ☐ Partnered ☐ Divorced ☐ Widowed

Occupation: ☐ Retired ☐Unemployed ☐ Employed/Job: _____ Employer:_____

Daytime phone: (____) _____ Other phone: (____) _____ Email: _____

How did you hear about us? ☐ My doctor ☐ Web ☐ Family/Friend ☐ Other: _____

Reason for visit? _____

Primary Care Physician name and phone:	Referring Physician name and phone:

What is your present Height: _____ Weight: _____ Blood Pressure: _____

PAST MEDICAL HISTORY (Please list any illnesses or medical problems you have had, and the approximate dates of their occurrence)

_____ _____
_____ _____
_____ _____
_____ _____

PREVIOUS COLON CANCER SCREENING (Please list the most recent colon screenings you have undergone and the dates of their occurrence):

☐Flexible Sigmoidoscopy _____ ☐Barium Enema _____
☐Colonoscopy ☐ No ☐ Yes - Year: _____ Other: _____

PAST SURGICAL HISTORY (Please list all operations you have had and the dates of occurrence)

_____ _____
_____ _____

FAMILY HISTORY (Please list your family member and the disease associated)

☐Colon or Rectal Cancer _____ ☐Colon or Rectal Polyps _____
☐Ulcerative Colitis_____ ☐Crohn's Disease _____
☐Other_____

MEDICATION (Please list ALL medications that you are currently taking and **their doses**. Please include over-the-counter and herbal, vitamins, aspirin, fish oil, etc.)

Name of Medication	**Strength** (i.e.: mg, mL, units, etc.)	**Frequency (**i.e.: once a day, 2x a day, etc.)

PHARMACY:

Name: _____
Address: _____
Phone: _____

ALLERGIES

Do you have any allergies to medications? ☐NO ☐YES, please list the drugs and type of **reaction** below:

_____

SOCIAL HISTORY

	NO	YES	
Do you currently smoke?	☐	☐	Packs/Day _____
Have you ever smoked?	☐	☐	Year you quit: _____
Do you drink alcohol?	☐	☐	Drinks/week: _____
Have you ever used intravenous drugs?	☐	☐	
Do you have children?	☐	☐	How many: _____

REVIEW OF SYSTEMS (Do you currently have or had a history of the following? Please check all that apply:

General
- ☐Recurrent fever
- ☐Significant weight change
- ☐Sweats
- ☐Anorexia
- ☐Fatigue
- ☐Malaise
- ☐Sleep disorder

Eye, Ear, & Throat
- ☐Cataracts
- ☐Glaucoma
- ☐Tinnitus
- ☐Decrease Hearing
- ☐Nosebleeds
- ☐Hoarseness

Cardiovascular
- ☐Abnormal heart valve
- ☐High blood pressure
- ☐Heart murmur
- ☐Heart attack
- ☐Peripheral Edema
- ☐High cholesterol
- ☐Irregular heartbeat
- ☐Pacemaker

Respiratory
- ☐Wheezing
- ☐Asthma
- ☐Shortness of breath
- ☐Productive cough
- ☐Sleep apnea/CPAP

Abdominal/GI
- ☐Hernia
- ☐Peptic Ulcer
- ☐Difficulty swallowing
- ☐Reflux
- ☐Jaundice
- ☐Vomiting
- ☐Vomiting Blood
- ☐Gas/bloating
- ☐Diarrhea
- ☐Abdominal Pain
- ☐Indigestion/ heartburn
- ☐Constipation
- ☐Nausea
- ☐Change in bowel habits
- ☐Bloody BMs
- ☐Black BMs
- ☐Fecal incontinence

Urologic / Reproductive
- ☐Frequent urination
- ☐Difficulty urinating
- ☐Blood in the urine
- ☐Urinary incontinence
- ☐Urinary hesitancy
- ☐Nocturnal urination
- ☐Prostate problems
- ☐Vaginal discharge
- ☐Number of pregnancies

Rheumatologic
- ☐Joint swelling
- ☐Joint pain
- ☐Arthritis
- ☐Shoulder pain /hand/wrist
- ☐Low back pain
- ☐Muscle weakness
- ☐Leg pain with exertion

Dermatologic
- ☐Rash
- ☐Itching
- ☐Hives
- ☐Skin cancer
- ☐Unhealing ulcers

Neurologic/Psychiatric
- ☐Seizure
- ☐Fainting or blackouts
- ☐Anxiety
- ☐Depression
- ☐Stroke
- ☐Paralysis
- ☐Tremors
- ☐Frequent headaches
- ☐Difficulty walking
- ☐Sciatica
- ☐Confusion
- ☐Memory loss

Endocrine
- ☐Diabetes
- ☐Thyroid problems
- ☐Steroid use

Hematologic
- ☐Bruising
- ☐Bleeding
- ☐Blood thinner use

Oncologic
- ☐Radiation
- ☐Chemotherapy

Other: _____

Do you have any religious objection to blood transfusion? ☐NO ☐YES_____

Patient Signature _____ _____ Date:_____
Entered to EMR by _____ Date: _____

I have reviewed the above information with the patient on this date

Physician's Signature_____ Date:_____

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PATIENT INFORMATION

Today's Date:_____ Referring Physician: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Sex: M ____ F____

Email address: _____ Primary Language_____ Ethnicity: _____ Race: _____

Home Phone: _____ Cell Phone: _____ Age: _____

Date of Birth: _____ Married: _____ Single: _____ Divorced: _____ Domestic Partner: _____ Widowed: _____

Patient Employer: _____ Work phone: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____ Occupation: _____

Emergency Contact: _____ Relationship_____ Phone: _____

Primary Insurance

Insurance Name: _____ Co-payment:$ _____

Policy Holder/Subscriber Name: _____ Relationship: _____ DOB: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance ID No. or Social Security #: _____ Group or Plan No.: _____

Secondary Insurance

Insurance Name: _____ Co-payment:$ _____

Policy Holder/Subscriber Name: _____ Relationship: _____ DOB: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance ID No. or Social Security #: _____ Group or Plan No.: _____

Responsible Party Person responsible for payment: (please circle) Self Spouse Father Mother Other

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Employer: _____ Work phone: _____

Address: _____

I understand that I am personally responsible for all charges by my physician whether or not paid for by insurance and guarantee payment of the bill. I authorize payment of the medical benefits directly to the physician. I also authorize release of medical or other information to my insurance company.

Signature Required Date

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Northwest Center for Colorectal Health (NWCCH), LLC as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned checks
  - Charge for missed appointments without 24 hours notice
- By my signature below, I hereby authorize assignment of financial benefits directly to NWCCH, LLC and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize NWCCH, LLC personnel to communication by mail, phone, and/or voice mail message, according to the information I have provided below:

Please read and then choose YES or NO:

- If you are unavailable, may we leave medical information from NWCCH, LLC office, such as normal blood test results or normal biopsy reports on your voice mail or with someone at your residence?
  _____YES – you may leave information as above
  _____NO – do not leave any information with anyone

If yes, please list name and relationship of person(s) we are authorized to discuss your medical care and/or account:

_____ _____

Name Relationship Name Relationship

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

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This Joint Notice of Privacy Practices (Notice) describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The Notice is being provided to you on behalf of Northwest Center for Colorectal Health LLC (NWCCH), its medical staff and other providers (collectively referred to herein as "we" or "our").

Northwest Center for Colorectal Health LLC is committed to protecting the confidentiality of your health information.

We are required by law to maintain the privacy of your protected health information (commonly called PHI or health information), including PHI in electronic format. We are also required to notify you of our legal duties and privacy practices regarding your health information and abide by the practices of this Notice, unless more stringent laws or regulations apply. This Notice applies to all Northwest Center for Colorectal Health LLC facilities, services and programs that provide health care to you.

Application of this Notice

The information privacy practices described in this Notice will be followed by:

- Any health care professional who treats you at any of our locations
- All facilities, departments and units, including hospitals, surgical centers, home care, clinics and other affiliates
- All workforce members such as employees, medical staff, trainees, students, volunteers and other persons under our direct control whether or not they are paid by us
- Other health care providers that have agreed to abide by this Notice of Privacy Practices

This Notice provides detailed information about how we may use and disclose your health information with or without authorization as well as more information about your specific rights with respect to your health information.

Uses and disclosures of your health information that we may make without your authorization

To contact you: Your information may be used to contact you to remind you about appointments, provide test results, inform you about treatment options or advise you about other health-related benefits and services.

Treatment: Your information may be shared with any health care provider who is providing you with health care services. This includes coordinating your care with other health care providers and providing referrals to other health care providers. Examples of health care providers who may need your information to treat you include your doctor, pharmacist, nurse and other providers such as physical therapists, home health providers, and X-ray technicians. We may share your information electronically with your health care providers in order to make sure they have your information as quickly as possible to treat you.

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We may share your health information with any family member or friend who is involved in assisting with your health care. We will only do this if you agree or do not object, and will only share with them the information they need in order to help you. If you are unable to either agree or object to such a disclosure, we may disclose your health care information as necessary if we determine that it is in your best interest based on our professional judgment.

We may disclose health information to a family member, relative or another person who was involved in your health care or payment for health care when you are deceased if not inconsistent with your prior expressed preferences.

Payment: In order to obtain payment for your health care services, we may have to provide your health information to the party responsible for paying. This may include Medicare, Medicaid (state health plan) or your insurance company. Your insurance company or health plan may need your information for activities such as determining your eligibility for coverage, reviewing the medical necessity of the health care services provided to you or providing approval for hospital services or stays.

Health care operations: Your health information may be used in order to support our business activities and to assure that quality health care services are being provided. Some of these activities include quality assessments, peer or employee review, training of medical personnel, licensure and accreditation, data aggregation and audits by regulatory agencies.

We may share your PHI with third parties who perform services such as transcription or billing. In those cases, we have written agreements with the third parties that they will not use or disclose your health information except if permitted by law.

We may also use your information (name, address, date of birth, department of service, treating physician, dates of treatment, outcome) for our fundraising activities.

You have the right to opt out of receiving such communications. If you do not want to receive these materials, please contact our foundation office and request that these materials not be sent to you.

Unless you object, your name and location may be included in our patient directory. If it is included, we will only share very limited information about you, such as your location in a hospital and general status, with anyone who asks about you by name. If you choose to provide your religious affiliation and do not object, we may provide your name and room number to clergy from your faith or religious community.

This Notice also describes the privacy practices of an Organized Health Care Arrangement (“OHCA”) between us and certain eligible health care providers and organizations. An OHCA allows legally separate covered entities to use and disclose PHI for the joint operation of the arrangement.

We participate in such an arrangement of health care organizations who have agreed to work with each other to facilitate access to health information relevant to your care. For example, if you present to a hospital for emergency care and cannot provide important information about your health, the OHCA will allow us to use your PHI from our OHCA participants to treat you. When it is needed, ready access to your PHI means better care for you. We store health information about our patients in a joint electronic health record with other health care providers who participate in this OHCA. Northwest Center for Colorectal Health LLC and members of the OHCA must be able to share your health information freely for treatment, payment and health care operations purposes. For this reason, we have created the OHCA and this Joint Notice. OHCA members may choose to have their own Notice(s). For information about organizations participating in our OHCA, please contact the Privacy Office listed in this Notice.

Other uses and disclosures that we may make without your authorization

There are a number of ways that your health information may be used or disclosed without your authorization. Generally, these uses and disclosures are either required by law or for public health and safety purposes.

When required by law: We may use or disclose your health information when required by law. If this happens, we will comply with the law and will only disclose the information necessary.

Public health: We may disclose your health information to a public health authority for public health activities. Public health activities include preventing or controlling disease, injury, disability, and responding to reports of abuse, neglect or domestic violence. We may disclose your health information to a person or agency required to report adverse events, product defects or problems, biologic product deviations, or for product recalls, repairs or replacements. Any disclosures of this nature will be made consistent with state and federal law.

Health oversight: We may disclose your health information to health oversight agencies for oversight activities authorized by law, such as audits, investigations, and inspections. Health oversight agencies include government agencies that oversee the Health care system, government benefit programs, government regulatory programs and civil rights.

Legal proceedings: We may use or disclose your health information in response to a court or administrative order in an administrative or judicial proceeding, or in response to a subpoena, discovery request or other legal process.

Law enforcement: We may use or disclose your health information for law enforcement purposes. Examples include (1) responding to legal processes; (2) providing limited information to identify or locate a suspect; (3) providing information about crime victims; (4) reporting suspicion that death has occurred as a result of criminal conduct; (5) reporting a crime which occurred on our premises; and (6) for medical emergencies, reporting where it appears likely a crime occurred.

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Preventing a serious threat: We may use or disclose your health information if we believe in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or of the public. Disclosure may only be made to a person reasonably able to prevent or lessen the threat.

Coroners, funeral directors, and organ donation: We may disclose your health information to a coroner or medical examiner for identification purposes, determining cause of death or other legally required duties. We may disclose your health information to a funeral director in order to permit him/her to perform his/her duties. We may disclose your information to facilitate an organ, eye or tissue donation.

Research: We may disclose your health information to researchers, provided that the research has been approved by an Institutional Review Board and/or a Privacy Board, and the research protocols have been approved to ensure your privacy. We may disclose health care information about you to people preparing to conduct a research project.

Military activity and national security: We may disclose the health information of Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your health information to authorized federal officials to conduct national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive information.

Inmates/arrestees: We may use or disclose your health information to a correctional institution or law enforcement official if you are an inmate of a correctional facility or are in custody and the information is necessary to treat you or protect the health and safety of you, other inmates, employees at the correctional facility or others.

Workers' compensation: We may use or disclose your health information as necessary to comply with workers' compensation laws and other similar legally established programs.

Disaster relief: We may disclose health care information about you to an entity assisting in a disaster relief effort so that your family and friends can be notified about your condition, status, and location.

Uses and disclosures of your health information that we may make with your authorization

Certain uses and disclosures of your health information, including marketing, sale of health information or release of psychotherapy notes, will be made only with your written authorization. You may revoke an authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization.

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Uses and disclosures not otherwise described in this Notice will be made only with your written authorization. Federal and state laws may place additional limitations on the disclosure of your health information for drug or alcohol abuse treatment programs, sexually transmitted diseases, or mental health treatment programs. When required by law, we will obtain your authorization before releasing this type of information.

Your Rights

Right to request restrictions: You have the right to ask us to place restrictions on the way we use or disclose your health information for treatment, payment or health care operations. We will consider your request but are not required to agree to the restriction (except as described below). If we agree to a restriction, we will not use or disclose your health information in violation of that restriction unless it is needed for an emergency. If a restriction is no longer feasible, we will notify you.

Right to restrict disclosure to health plans: You may request in writing, at the time of service, that we not disclose information to health plans where you have paid for items or services out of pocket in full. We must agree not to disclose this information to your health plan if certain conditions are met.

Confidential communications: We will accommodate reasonable requests to communicate with you about your health information by different methods or alternative locations. For example, if you are covered on a health plan but are not the subscriber, and would like your health information sent to a different address than the subscriber, we can usually do that for you.

Breach notification: You have the right to receive notification of breaches of your health information as required by law.

Access to your health information: You have the right to receive a copy of your health information that we maintain, with some limited exceptions. You may request access to your information in writing, and you may request a copy of your information in electronic format. We reserve the right to charge a reasonable fee for the cost of producing and providing your health information. You have the right to request that your health information be sent to any person or entity, such as another doctor, caregiver or online personal health record.

Amendment of your health information: You have the right to ask us to amend any of your health information. You need to request this amendment in writing and submit it to the facility's medical records department. We may deny your request in certain situations, such as when the health information in your records was created by another provider or if we determine your information is accurate and complete. Any denials will be in writing. You have the right to appeal our denial by filing a written statement of disagreement.

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Accounting of certain disclosures: You have a right to a listing of the disclosures we make of your health information, except for those disclosures made for treatment, payment, or health care operations, or those disclosures made pursuant to your authorization. The type of disclosures typically contained in a listing would be disclosures made for mandatory public health purposes, law enforcement, legal proceedings, or for other required reporting such as birth and death certificates.

Exercising your rights: To exercise any of the above rights or if you need to share your health information with someone for purposes other than those listed here, contact the appropriate medical records department.

Questions and complaints

If you have questions or are concerned that any of your privacy rights have been violated, please contact our Privacy Officer.

You also have the right to complain to the Secretary of Health and Human Services at:

Office for Civil Rights – AK, WA, OR, MT
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831

Office for Civil Rights – CA
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

You will not be retaliated against for filing a complaint.

Changes to Joint Notice of Privacy Practices

We reserve the right to change the terms of our Notice at any time. New Notice provisions will be effective for all protected health information that we maintain. You may view a copy of our most current Notice on our website at www.NWCCH.com, or request a current copy from the medical records department, privacy officer, or registration staff at any time.

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ACKNOWLEDGMENT AND CONSENT

I understand that NW Center for Colorectal Health, LLC (referred to below as "this Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written descriptions known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practices is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that <u>I have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

Date of Birth:_____

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority

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AUTHORIZATION FOR THE RELEASE OF PATIENT MEDICAL RECORDS

Send To: NW Center for Colorectal Health, LLC
9155 SW Barnes Rd., Suite 231, Portland, OR 97225
Fax: 503-216-5399

Re: Patient name:_____

Date of birth:_____

I authorize and request the disclosure of all protected information for the purpose of (reason):

_____

I expressly request that the designated record custodian disclose full and complete protected medical information including the following **(initial each item to be included):**

NOTE: ONLY THOSE ITEMS INITIALED WILL BE INCLUDED IN THE RELEASED INFOMATION

___ All hospital records
___ Transcribed hospital records
___ Medical records needed for continuity of care
___ Lab reports
___ Path reports
___ Diagnostic imaging reports
___ Most recent five year history
___ Clinician office chart notes
___ Dental records
___ Physical therapy records
___ Billing statements
___ Other _____

___ HIV/AIDS related records
___ Mental health information
___ Genetic testing information
___ Drug/alcohol diagnosis, treatment or referral information as listed on back (Federal Regulation 42CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on reverse of this form)

___ Send the entire medical record (all information) to the above named recipient.

This authorization is limited to the following treatment(s):_____

This authorization is limited to the following time period:_____

This authorization is limited to work comp claim for injuries incurred on _____
Date

This authorization may be revoked at any time (in writing) except to the extent information has been released in reliance upon this authorization.

_____ _____
Date Signature of patient or legally authorized representative

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To our valued patients,

In an effort to avoid any potential confusion about charges for your visit at Northwest Center for Colorectal Health LLC, we would like to inform you of charges that may be associated with your office exam. In the course of examining anorectal problems it is often necessary to perform anoscopy or proctoscopy in order to identify the problem, and these are separate additional billable services. These diagnostic evaluations are considered "procedures" by insurance companies and therefore your insurance carrier may apply deductible and co-insurance when processing these charges.

You may wish to contact your insurance carrier to verify any out of pocket expenses should one of these "procedures" be necessary.

Actual out of pocket cost will be determined by your insurance carrier by applying network discounts, if applicable, and your specified benefits.

The CPT Codes for anoscopy and proctoscopy are 46600 and 45300, respectively.

By signing below you are indicating your acknowledgement and understanding of the above statement.

_____

Signature of patient or Guardian Date

_____

Please Print name Date of birth