



BRADLEY L. FREILICH, MD
 S. FAISAL JAFRI, MD
 JANAY KISSINGER, RN, MSN, APRN, BC

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| DATE |
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PHONE 816-361-0055
 FAX 816-361-5775
 WEBSITE www.kcgastro.com

DEMOGRAPHICS

| | | | | | |
|-------------------|---------------|---------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| LAST NAME | FIRST NAME | MI | SEX | <input type="checkbox"/> MALE | <input type="checkbox"/> FEMALE |
| ADDRESS | | CITY | ST | ZIP | |
| SSN | DATE OF BIRTH | <input type="checkbox"/> SINGLE | <input type="checkbox"/> MARRIED | <input type="checkbox"/> WIDOWED | <input type="checkbox"/> DIVORCED |
| HOME PHONE | WORK PHONE | CELL PHONE | EMPLOYER | | |
| E-MAIL ADDRESS | | REFERRING PHYSICIAN | | | |
| EMERGENCY CONTACT | RELATION | PHONE NUMBER | | | |
| PHARMACY NAME | ADDRESS | PHONE NUMBER | | | |

INSURANCE

| | | |
|---------------------|---------------|----------|
| PRIMARY INSURANCE | ID # | GROUP # |
| CLAIM ADDRESS | POLICY HOLDER | RELATION |
| SECONDARY INSURANCE | ID # | GROUP # |
| CLAIM ADDRESS | POLICY HOLDER | RELATION |

GUARDIAN

| | | | |
|-------------------|-------------|------------|----------|
| RESPONSIBLE PARTY | RELATION | | |
| ADDRESS | CITY ST ZIP | | |
| HOME PHONE | WORK PHONE | CELL PHONE | EMPLOYER |

THERE IS A 48 HOUR CANCELLATION POLICY FOR ALL OFFICE VISITS AND PROCEDURES. IF WE DO NOT RECEIVE 48 HOURS NOTICE, YOU WILL BE CHARGED A \$25 FEE FOR A MISSED OFFICE VISIT OR A \$100 FEE FOR A MISSED PROCEDURE.

IF YOUR COLONOSCOPY HAS BEEN SCHEDULED AS A SCREENING (YOU HAVE NO SYMPTOMS) AND YOUR DOCTOR FINDS A POLYP OR TISSUE THAT HAS TO BE REMOVED DURING THE PROCEDURE, THIS COLONOSCOPY IS NO LONGER CONSIDERED A SCREENING PROCEDURE, IT IS CONSIDERED A SURGICAL PROCEDURE AND YOUR INSURANCE BENEFITS MAY CHANGE. PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO STARTING THE BOWEL PREPARATION.

ASSIGNMENT OF BENEFITS

I certify that the information given by me in applying for payment is correct. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Kansas City Gastroenterology & Hepatology, LLC and associates for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services. I request that payment of authorized insurance benefits be made on my behalf to Kansas City Gastroenterology & Hepatolog, LLC and associates for any services furnished to me. I authorize any medical information concerning me to be released to my insurance companies to determine these benefits or the benefits payable for related services.

| | | |
|--------------|-----------|------|
| PATIENT NAME | SIGNATURE | DATE |
|--------------|-----------|------|



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FINANCIAL POLICY

Prior to treatment, everyone must provide payment authorization by credit card to cover all unknown **PATIENT RESPONSIBLE BALANCES** after your insurance company pays (with the exception of Medicare beneficiaries). We would like to take this opportunity to welcome you to your office, and to let you know we are committed to providing you with the best possible care. Please take the time to read this information so there is no misunderstanding as to what our Financial Policy is. We will gladly discuss your proposed treatment and answer any questions related to your insurance.

If you do not have insurance, **payment for services is due at the time services are rendered**, unless payment arrangements have been made in advance. Acceptable forms of payment at this time are cash, check, MasterCard and Visa.

If you do have insurance, we will be happy to file your claim for you **as a courtesy** provided you have signed the assignment of insurance benefits on the previous page. However, you should realize that your insurance coverage is a contract between you and your insurance company. Payment to us is ultimately your responsibility and if payment from your insurance company is not received, payment in full from you is necessary. Please note that not all services are a covered benefit in all contracts. Some services may be specifically excluded in your contract as contracts can vary from plan to plan as well as from patient to patient. **We advise patients to check your benefits to make sure your visit/procedure would be a covered benefit for you.**

If your insurance company requires you to pay a co-pay, it is due at the time of service. **If your insurance requires a referral or authorization, it is your responsibility to acquire it from your Primary Care Physician.** Please be sure to bring your referral with you to your appointment. Services can not be rendered if proper authorization has not been given for your visit.

We realize that on occasion financial problems may arise which might affect the timely payment of your account. If you do find yourself experiencing some financial difficulty, please contact our office as soon as possible and we will gladly assist you in managing your account. Should we deem it necessary, we may use the help of outside agencies in an effort to collect severely overdue accounts.

I have read and agree to the cancellation policy on the first page of this form, as well as the terms and conditions listed above. I understand that I am financially responsible to Kansas City Gastroenterology & Hepatology, LLC for charges denied or not covered by my insurance company. I further agree that in the event of non-payment, I will be responsible for and pay for any costs of collection, court costs, statutory interest and attorney's fees should this be required.

| | | |
|--------------|-----------|------|
| MC/VISA # | EXP DATE | CCV |
| PATIENT NAME | SIGNATURE | DATE |

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY POLICY **You may refuse to sign this acknowledgement**

I, _____, have been provided with a copy of the notice of privacy practices.

| | |
|-----------|------|
| SIGNATURE | DATE |
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PERMISSION TO DISCLOSE INFORMATION

I hereby allow the practice of Kansas City Gastroenterology & Hepatology, LLC to disclose information to the following people: _____ in the following forms of communication:

| | |
|---|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Home Telephone |
| <input type="checkbox"/> Spouse _____ DOB _____ | <input type="checkbox"/> Work Telephone |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Cellular Telephone |
| SIGNATURE _____ | <input type="checkbox"/> Home Voice messaging system |
| DATE _____ | <input type="checkbox"/> Work Voice messaging system |
| | <input type="checkbox"/> Mail |

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

| | |
|--|--|
| <input type="checkbox"/> Individual refused to sign | <input type="checkbox"/> An emergency situation prevented us |
| <input type="checkbox"/> Communication barriers prohibited the acknowledgement | <input type="checkbox"/> Other _____ |

HIPAA

PATIENT HISTORY CONTINUED

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|--------------|------|
| PATIENT NAME | DATE |
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PERSONAL/FAMILY HISTORY

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|---|--------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|--|
| ALLERGIES | SURGERY/HOSPITALIZATION | DATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FAMILY HISTORY: <table style="display: inline-table; vertical-align: top; margin-left: 10px;"> <tr> <td style="width: 15%;">FATHER</td> <td style="width: 15%;">MOTHER</td> <td style="width: 15%;">SIBLING</td> <td style="width: 15%;">OTHER</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> | FATHER | MOTHER | SIBLING | OTHER | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| FATHER | MOTHER | SIBLING | OTHER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GALL STONES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ULCERS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| COLON POLYPS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PANCREATITIS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| COLON CANCER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OTHER CANCER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LIVER DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

SOCIAL HISTORY

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|---|--|---|--|---|
| OCCUPATION/ HOBBIES | HISTORY OF EXPOSURE: | <input type="checkbox"/> IV DRUG USE <input type="checkbox"/> TATTOOS <input type="checkbox"/> COCAINE USE <input type="checkbox"/> ACCUPUNCTURE <input type="checkbox"/> BLOOD TRANSFUSION PRIOR TO 1991 | <input type="checkbox"/> ALCOHOL PERIOD OF TIME? <input type="checkbox"/> 1 OZ/DAY <input type="checkbox"/> 2 OZ/DAY <input type="checkbox"/> 4 OZ/DAY <input type="checkbox"/> > 6 OZ/DAY | <input type="checkbox"/> BEER PERIOD OF TIME? <input type="checkbox"/> 1/DAY <input type="checkbox"/> 2/DAY <input type="checkbox"/> > 4/DAY |
| <input type="checkbox"/> TOBACCO <input type="checkbox"/> CIGARETTES PACKS PER DAY _____ <input type="checkbox"/> PIPE _____ <input type="checkbox"/> CHEWING TOBACCO _____ <input type="checkbox"/> COFFEE: MORE THAN 2 CUPS PER DAY | <input type="checkbox"/> PERIOD OF TIME? _____ | | | |

REVIEW OF SYSTEMS

| | | |
|---|---|---|
| GASTROENTEROLOGY YES NO <input type="checkbox"/> <input type="checkbox"/> POOR APPETITE <input type="checkbox"/> <input type="checkbox"/> DIFFICULTY SWALLOWING <input type="checkbox"/> <input type="checkbox"/> HEARTBURN <input type="checkbox"/> <input type="checkbox"/> NAUSEA <input type="checkbox"/> <input type="checkbox"/> VOMITTING <input type="checkbox"/> <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> <input type="checkbox"/> DIARRHEA <input type="checkbox"/> <input type="checkbox"/> BLOOD IN STOOL <input type="checkbox"/> <input type="checkbox"/> ABDOMINAL PAIN | DERMATOLOGY YES NO <input type="checkbox"/> <input type="checkbox"/> RASH <input type="checkbox"/> <input type="checkbox"/> ITCHING | GENERAL YES NO <input type="checkbox"/> <input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> <input type="checkbox"/> WEIGHT GAIN <input type="checkbox"/> <input type="checkbox"/> FEVER <input type="checkbox"/> <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> <input type="checkbox"/> FATIGUE |
| | ENDOCRINOLOGY YES NO <input type="checkbox"/> <input type="checkbox"/> HEAT INTOLERANCE <input type="checkbox"/> <input type="checkbox"/> COLD INTOLERANCE <input type="checkbox"/> <input type="checkbox"/> HAIR LOSS | MUSCULOSKELETAL YES NO <input type="checkbox"/> <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> <input type="checkbox"/> JOINT SWELLING <input type="checkbox"/> <input type="checkbox"/> BACK PAIN <input type="checkbox"/> <input type="checkbox"/> MUSCLE PAIN |
| CARDIOLOGY YES NO <input type="checkbox"/> <input type="checkbox"/> CHEST PAIN <input type="checkbox"/> <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> <input type="checkbox"/> SWELLING OF ANKLES <input type="checkbox"/> <input type="checkbox"/> DIZZINESS | NEUROLOGY YES NO <input type="checkbox"/> <input type="checkbox"/> HEADACHE | PSYCHIATRIC YES NO <input type="checkbox"/> <input type="checkbox"/> MEMORY LOSS <input type="checkbox"/> <input type="checkbox"/> CONFUSION <input type="checkbox"/> <input type="checkbox"/> DEPRESSION <input type="checkbox"/> <input type="checkbox"/> ANXIETY <input type="checkbox"/> <input type="checkbox"/> TENSION/STRESS <input type="checkbox"/> <input type="checkbox"/> SLEEP DISTURBANCES |
| | OPHTHALMOLOGY YES NO <input type="checkbox"/> <input type="checkbox"/> DIMINISHED VISION | |



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NOTICE OF PRIVACY PRACTICES - EFFECTIVE APRIL 14, 2003

As part of our patients rights regarding the confidentiality of their medical records, new Federal Government regulations require our practice to give our patients a copy of our Policy of Information Practices. This policy states how information about you may be used and disclosed. Federal Government regulations also require us to have your signature on file stating that we gave you a copy of our Policy of Information Practices. This does not replace any required authorizations signed by you in order to have your medical records sent out of our office. Thank you for your help in keeping our office in compliance with Federal Rules & Regulations. If you have any questions, you may check out this website at <http://www.hhs.gov>.

Your Health Record

Each time you visit or call the practice of Kansas City Gastroenterology & Hepatology, LLC a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a: Basis for planning your care and treatment, means of communication among the many health professionals who contribute to your care, legal documentation describing the care you received, means by which you or a third party payer can verify that services billed were actually provided, a tool in educating health professionals, a source of data for medical research, a source of information for public health officials charged with improving the health of the nation, a source of data for facility planning and marketing, a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, make more informed decisions with authorizing disclosure to others.

Health Information Rights

The information in the health records we maintain belongs to you. You have the right to: request a restriction of certain uses and disclosures of your information, obtain a paper copy of the notice of information practices upon request, inspect and copy the health record, request an amendment of the health records, obtain an accounting of disclosures of the health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

This Organization is required to: maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, Notify you if we are not able to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice. If you have any questions, you may contact the office at 816-361-0055. If you believe your privacy rights have been violated, you can file a complaint with the office administrator or with the Secretary of Health and Human Services, Office of the Secretary, 200 Independence SW, Washington, DC 20201. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations:

We will use your health information for treatment. For example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observation. In that way the physician will know how you are responding to the treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you. We will use your health information for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Uses or Disclosures:

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the Emergency Department and Radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information. **Notification:** We may use or disclose information to notify a family member or another person responsible for your care or payment. **Communication with family:** Health professionals, using their best judgement, may disclose to a family member, other relative or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We may contact you by phone and/or mail to provide appointment reminders. **Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement. **Public Health:** As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. **Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals. **Law Enforcement:** We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards are potentially endangering one or more patients, workers or the public.