

Gastroenterology  
Institute  
*of West Michigan, P.C.*

SHAUKAT ALI KHAN M.D., F.A.C.G.

*Gastroenterology, Endoscopy, IBD, and Hepatology*

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1430 MICHIGAN ST., N.E., SUITE A  
GRAND RAPIDS, MI 49503-2006

PHONE: (616) 459-6146 • FAX (616) 459-9277

WE ARE PROVIDING YOU WITH PAPERS THAT NEED TO BE FILLED OUT PRIOR TO YOUR ARRIVAL. THIS WILL FACILITATE AN EXPEDITED PROCESSING THROUGH OUR OFFICE. WE WOULD LIKE YOU TO BRING YOUR INSURANCE CARDS WHEN YOU COME FOR YOUR APPOINTMENT. ALL CO-PAYS WILL BE COLLECTED AT TIME OF SERVICE. WE ACCEPT CASH OR CHECK. AT THIS TIME WE ARE NOT ACCEPTING CREDIT OR DEBIT CARDS. FREE PARKING IS ADJACENT TO THE BUILDING. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE AND WE WILL BE GLAD TO ANSWER THEM.



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AUTHORIZATION FOR RELEASE OF INFORMATION

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PERMISSION IS GRANTED FOR YOU TO RELEASE COPIES OF MY  
MEDICAL RECORDS, LABS AND ALL X-RAYS TO:

DR. SHAUKAT A. KHAN  
GASTROENTEROLOGY INSTITUTE OF WEST MICHIGAN, PC  
1430 MICHIGAN NE, SUITE A  
GRAND RAPIDS, MI 49503  
(616) 459-6146 – FAX: (616) 459-9277

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

PLEASE PRINT

NAME: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MARITAL STATUS:    SINGLE    MARRIED    SEPARATED    DIVORCED    WIDOWED

TELEPHONE: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ S.S. #: \_\_\_\_\_

DRIVERS LICENSE #: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ POLICY #'s: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

EMPLOYER: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

SPOUSE'S S.S. #: \_\_\_\_\_

SPOUSE'S INS. (if different): \_\_\_\_\_ POLICY #'s: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

NAME OF CLOSE FRIEND OR RELATIVE: \_\_\_\_\_

NOT LIVING WITH YOU (PLEASE SPECIFY)

TELEPHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

WHO WILL BE RESPONSIBLE FOR THIS BILL: \_\_\_\_\_

DO YOU AUTHORIZE RELEASE OF YOUR MEDICAL INFORMATION TO ANYONE BESIDES YOUR INSURANCE

CARRIER:            YES            NO

IF YES, WHOM: \_\_\_\_\_

DATE: \_\_\_\_\_

WEST MICHIGAN GASTROENTEROLOGY INSTITUTE, P.C.

**PART I (To Be Filled Out By Patient)** REFERRING DOCTOR'S NAME \_\_\_\_\_

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
Last First Middle

STREET \_\_\_\_\_ CITY & STATE \_\_\_\_\_

PHONE: Home \_\_\_\_\_ Business \_\_\_\_\_  
Area Code Number Area Code Number

SEX: Male \_\_\_ Female \_\_\_ EDUCATION: Yrs in high school \_\_\_ College \_\_\_

MARITAL STATUS: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

OCCUPATION(s) : \_\_\_\_\_

NAME & PHONE NUMBER OF CLOSE FRIEND OR RELATIVE \_\_\_\_\_

**YOUR HEALTH HISTORY.** Please provide the following information as best you can:

**What brings you to see the doctor today?**

List all the medications you are taking, especially blood thinners and steroids, and including over-the-counter drugs.

Do you take any pain medications? Also include over-the-counter medications such as aspirin, ibuprofen, Excedrin, Motrin, Aleve, Alka-Seltzer, etc.:

Do you have any **drug allergies**? Give the name of the medication and what allergic reaction it caused:

Have you had any psychiatric care? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, what was your diagnosis? \_\_\_\_\_ Please give name of doctor: \_\_\_\_\_.

List any foreign countries visited in the last 3 years:

FAMILY HISTORY: Is there anyone in your family who has had colon polyps, colon cancer, ulcers, bowel disease, gallbladder disease, liver disease, kidney stones, etc.?

Any food intolerance? \_\_\_\_\_ Do you take oxygen at home? \_\_\_\_\_

Are antibiotics recommended for you before a dental procedure? \_\_\_\_\_

If you have had any of the following, please circle the illness and indicate when you had it:

Heartburn	Anemia	Car Accidents
Indigestion	Jaundice/Liver Disease	Difficulty Breathing
Gas/Ulcers	Irregular Heartbeat	Emphysema/Asthma
Colitis	Heart Attack	Kidney Disease
Rectal Bleeding	Stroke	Rheumatic Fever High
Crohn's Disease	Headaches	Blood Pressure
Gallstones	Dizzy Spells/Blackouts	Arthritis Diabetes
Colon Cancer	Seizures	Depression
Pancreatitis	Sleep Disorder	Collagen Disease
Diarrhea	Thyroid Disease	Hepatitis

Have you had excessive bleeding after tooth extraction, cuts or injuries?\_\_\_\_\_

HOSPITALIZATIONS (for major illnesses or operations): Please list in chronological order as they occurred, with the name of doctor and hospital. Please do not list normal pregnancies.

<u>YEAR</u>	<u>OPERATION/ILLNESS</u>	<u>DOCTOR</u>	<u>HOSPITAL</u>	<u>CITY</u>
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____

TESTS: when did you **last** have the following test(s) done? Please indicate the month, year, location and result of each test.

<u>NAME OF TEST</u>	<u>MONTH/YEAR</u>	<u>LOCATION</u>	<u>RESULT</u>
Endoscopies done in the past_____	_____	_____	_____
Esophagogastroscopy_____	_____	_____	_____
Barium Enema (colon x-ray)_____	_____	_____	_____
Upper GI (stomach x-ray)_____	_____	_____	_____
Gallbladder Ultrasound _____	_____	_____	_____
CT Scan of Chest/Abdomen _____	_____	_____	_____
Colonoscopy _____	_____	_____	_____

**PART II (To Be Filled Out By Nurse)**

Smoking_____	How many bowel movements per 24 hrs_____
Alcohol_____	Is there blood in stools_____
Street Drugs_____	Appetite_____
Coffee_____	Early satiety, tenesmus_____
Tea_____	Weight change_____ Pregnant_____
Milk/Pop_____	Date of LMP_____ Gravida_____ Para_____
Sleep_____	Dysmenorrhea_____ Menorrhagia_____

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



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Section 1

**AUTHORIZATION FOR THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION**

By signing below, I hereby authorize my health information, as more specifically described as follows: Protected Health Information, to be used or disclosed for the following purposes: At the Patient's Request. The specific person or persons who are authorized to use or disclose my Protected Health Information are: (These three lines are for the names of friends or family members and their phone numbers that you give permission to call Dr. Khan's office and receive results of tests or other medical record information. If you do not want to list anyone's name, draw a line through that section, write "none" and initial it .)

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This Authorization shall expire in one year. I understand that I have the right to revoke this authorization, if the revocation is in writing, except if: This office has taken action in reliance upon this Authorization; or This Authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to consent a claim made under the Insurance policy.

I understand that I may revoke this Authorization by delivering written notice to: Gastroenterology Institute of West Michigan, P.C., 1430 Michigan St., NE. Grand Rapids, Michigan 49503-2006. I understand that if my Protected Health Information is used or disclosed, the privacy of my Protected Health Information will no longer be protected. I acknowledge that I have read and understand this Authorization. I authorize the use of disclosure of my Protected Health Information in accordance with the terms of this Authorization.

I hereby authorize GASTROENTEROLOGY INSTITUTE OF WEST MICHIGAN PC to release any information and/or medical data acquired in the course of my examination or treatment to my referring physician, insurance company and my employer as necessary for the purpose of obtaining insurance benefits.

I authorize payment direct to GASTROENTEROLOGY INSTITUTE OF WEST MICHIGAN PC for surgical services and medical benefits payable to the service related here in.

We will submit claims on your behalf to your primary insurance company. Co-pays, co-insurances, deductibles, and any non-covered services are all the patient's responsibility.

**ANY AUTHORIZATION OR PRE-CERTIFICATION THAT IS REQUIRED BY INSURANCE COMPANIES IS THE PATIENT'S RESPONSIBILITY.**

\_\_\_\_\_  
Patient Initial

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Section 2

**CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION**

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your information in our possession (collectively "Protected Health Information").

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

For more complete description of how this office may use or disclose your Protected Health Information, please carefully review the Notice of Privacy Practices Form that has been prepared and is furnished to you today. Please also see our Notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment," "payment," and "health care operations".

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THIS OFFICE MAY REVISE THE NOTICE OF PRIVACY PRACTICES FORM FROM TIME TO TIME. ANY SUCH REVISED NOTICE OF PRIVACY PRACTICES FORM WILL BE MADE AVAILABLE TO YOU BY CONTACTING DR. SHAUKAT A. KHAN, PRIVACY OFFICER. YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT ARE AVAILABLE TO YOU WITH RESPECT TO THIS OFFICE'S USE AND DISCLOSURE OF YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.

Section 3

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of this Notice of Privacy Practices Form from Gastroenterology Institute of West Michigan, P.C.

**Documentation of Failure to Obtain Signed Acknowledgement**

On \_\_\_\_\_, 2008 \_\_\_\_\_ presented this Acknowledgement of Receipt Of Notice of Privacy Practices Form to \_\_\_\_\_ (the "Patient"). The patient has refused to provide a signature when requested.

**By signing below, you have acknowledged that you have read and understand this consent.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

PATIENT RECORD OF DISCLOSURES

Patient Name: \_\_\_\_\_

In general, the HIPPA privacy rule gives individuals the right to request a restriction on the use and disclosure of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications of their PHI or make a request of their PHI by alternative means such as sending correspondence to the individual's office.

Home Telephone \_\_\_\_\_

Written Communication

OK to leave message with detailed information.

OK to mail to my home address

Leave message with call-back number only

OK to leave detailed message on answering machine

\_\_\_\_\_  
\_\_\_\_\_

OK to leave detailed message on voicemail

OK to mail to my work/office address

OK to leave message with the following:

\_\_\_\_\_  
\_\_\_\_\_

Name:

\_\_\_\_\_

Name:

\_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth



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**NOTICE OF PRIVACY PRACTICES**

**EFFECTIVE APRIL 14, 2003**

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: SHAUKAT A. KHAN, MD, PRIVACY OFFICER.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you received at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information,

This office is 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. The following describes the different ways that your medical information may be used or disclosed by this office. Not every possible use or disclosure is specifically mentioned. However, all of the ways we permitted to use and disclose your medical information will fit within one of these general categories:

**FOR TREATMENT:** We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you with medical treatment.

**FOR PAYMENT:** We may use and disclose medical information about you so that the treatment and services you received 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 for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. We may also combine medical information about many of our patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patients.

**APPOINTMENT REMINDERS:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

**TREATMENT ALTERNATIVES:** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**HEALTH-RELATED BENEFITS & SERVICES:** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**RESEARCH:** Under certain circumstances we may use and disclose medical information about you for research purposes. For example: A research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

**AS REQUIRED BY LAW:** We will disclose medical information about you when required to do so by federal, state or local laws.

**TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.

**HEALTH OVERSIGHT ACTIVITIES:** We may use and disclose medical information to a governmental or other agency for activities authorized by law.

**LAWSUITS & DISPUTES:** If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

**LAW ENFORCEMENT:** We may release medical information about you if required by law when asked to do so by law enforcement official.

**CORONERS & MEDICAL EXAMINERS:** We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION THIS OFFICE MAINTAINS ABOUT YOU:**

**RIGHT TO INSPECT & COPY:** You have the right to inspect and copy your medical information with the exception of any psychotherapy notes.

To inspect and copy your medical information, you must submit your request in writing to Dr Shaukat A. Khan, Privacy Officer, 1430 Michigan St., NE, Suite A, Grand Rapids, MI 49503. If you request a copy of the information, we may charge a fee for the cost 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 your medical information, you may request that the denial be reviewed. For information regarding such a review, contact Dr. Shaukat A. Khan, Privacy Officer.

**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 this office keeps the information. To request an amendment, your request must be made in writing and submitted to Dr. Shaukat A. Khan, Privacy Officer, 1430 Michigan St., NE, Suite A, Grand Rapids, MI 49503. In addition, you must provide a reason that supports your request. 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:

- (a) Was not created by us;
- (b) Is not part of the medical information kept by this office;
- (c) Is not part of the information which you would be permitted to inspect and copy; or
- (d) 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 the disclosures this office has made of your medical information. To request this accounting of disclosures, you must submit your request in writing to Dr. Shaukat A. Khan, Privacy Officer. Your request must state a time period, which may not be longer the six years and may not include dated before February 26, 2003.

**RIGHT TO REQUEST RESTRICTIONS:** You have the right to request a restriction or limitation on the use or disclosure we make of your medical information. We are not required to agree to your request for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restriction, you must make your request in writing to Dr. Shaukat A. Khan, Privacy Officer. 1430 Michigan St., NE, Suite A, Grand Rapids, MI 49503.

**RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS:** You have the right to request in writing to Dr. Shaukat A. Khan, Privacy Officer. We will accommodate all reasonable requests.

**RIGHT TO A PAPER COPY OF THIS NOTICE:** You have the right to a paper copy of the Notice. We do not have a website at this time. To obtain a paper copy of this Notice, contact Dr. Shaukat A. Khan, Privacy Officer, 1430 Michigan St., NE, Suite A, Grand Rapids, MI 49503.

**REVISIONS TO THIS NOTICE:**

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice in this office. Any revised Notice will contain on the first page. In the top right-hand corner, the effective date.

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact Dr. Shaukat A. Khan, Privacy Officer. All complaints must be submitted in writing.

**THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.**

**OTHER USES OF MEDICAL INFORMATION:**

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will longer use or disclose medical information about you for the reasons covered by your written authorization.