



NORTHWEST GASTROENTEROLOGY  
ASSOCIATES

**Open Access Registration Information**

Dear Patient,

Thank you for your interest in our Open Access Program (OA). OA is designed to provide healthy patients who need a specific procedure (upper endoscopy or colonoscopy) direct access to scheduling a procedure without a consultation.

Attached are documents that you will need to print and complete. Once complete you can email, mail or fax back to our office. If your procedure appointment is less than 3 weeks away, we require completed forms be returned within 72 business hours. If your procedure appointment is more than 3 weeks out, we require completed forms be returned within 7 business days. If your paperwork is not received in the time frame requested, your appointment will be cancelled, but can be rescheduled once your paperwork is received.

**Forms that need to be returned are:**

- Completed Registration Form/Race and Ethnicity Form**
- Signed HIPAA form**
- Completed Health History**
- Copy of the front and back side of your current medical insurance cards**
- If Medicare eligible, complete Medicare Form and Insurance Eligibility Questionnaire**

If you choose to email your paperwork, send to [info@nwgdocs.com](mailto:info@nwgdocs.com)

If you choose to fax your paperwork, fax to 425-462-8021, Attn: Open Access

If mailed, please return your paperwork to:

NWGA  
Attn: Open Access  
1135 116<sup>th</sup> Ave NE #560  
Bellevue, WA 98004

Within 4 weeks of your scheduled procedure, you will receive a telephone call from a member of our clinical staff so that we may review your health history and decide if you are eligible for our OA program. You may be asked to make an appointment with one of our providers based on the information you provide.

If you are using Open Access for colon cancer screening, be sure to check with your insurance company regarding your coverage as not all insurance companies cover screening colonoscopies. If your insurance requires a referral you will need to get this before the procedure.

If you should have any questions regarding the pre-registration process, please contact us at 425-990-2709. We are available to assist you Monday through Friday, 8:00am-5:00pm.

Sincerely,

Northwest Gastroenterology Associates

updated 8/12/2011



NORTHWEST GASTROENTEROLOGY ASSOCIATES

PATIENT INFORMATION (Please Print)

Full Name (LAST, FIRST, MI), Sex (Male/Female), Preferred Name, Social Security #, Birthdate, Age, Mailing Address, Street Address, Home Phone, Work Phone, Cell Phone, Employer, Occupation, Marital Status (Single, Married, Widowed, Divorced, Legally Separated, Other), Referred to NWGA by, Primary Care Physician.

INSURANCE INFORMATION

Primary Insurance Company: Insurance Name, Subscriber's Relationship to Patient (self, spouse, parent, other), Subscriber Name, Date of Birth, SSN, Policy ID #, Group #, Copay \$. Secondary Insurance Company: Insurance Name, Subscriber's Relationship to Patient (self, spouse, parent, other), Subscriber Name, Date of Birth, SSN, Policy ID #, Group #, Copay \$.

RESPONSIBLE PARTY INFORMATION Complete - if child is a minor

Full Name, Relationship to Patient (parent, other), Mailing Address, City, State, Zip.

EMERGENCY CONTACT

Name, Day/Work Phone, Relationship to Patient, Home/Eve Phone.

RELEASE OF INFORMATION - Read Carefully

As a patient you have certain responsibilities for your care. Those responsibilities include:

- Providing current, accurate billing information at all visits.
• Provide physician with complete medical history.
• Being aware of which benefits your insurance does and does not cover.
• Failure to cancel appointments 24 hrs. in advance may result in a fee.

Primary Language, Race, Ethnicity.

I hereby authorize my insurance benefits to be paid directly to Northwest Gastroenterology Associates and I am financially responsible for any balance due. I authorize Northwest Gastroenterology Associates to release any information necessary to process an insurance claim, including industrial injury.

My Signature acknowledges understanding and consent to all of the above information.

Signature, Date.

PATIENT OR PARENT/GUARDIAN IF SIGNING FOR MINOR

How did you find out about our office? (check one): Insurance, Another MD, ER, Existing, Patient, Family, Friend, Yellow Pages, Overlake Referral Line, Other.



NORTHWEST GASTROENTEROLOGY ASSOCIATES

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

We keep a record of the health care services we provide to our patients. You may ask to see or receive a copy of that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Check One:

- By my signature below I acknowledge receipt of the Notice of Privacy Practices.
By my signature below I acknowledge that I have declined to receive a copy of the Notice of Privacy Practices. I have been made aware that the complete Notice of Privacy Practices is available to me at any time.

Signature of patient or patient's authorized representative Date signed

Relationship if signed by anyone other than patient

CONSENT TO LEAVE MESSAGES/DISCLOSE INFORMATION/OBTAIN MEDICATION HISTORY

I give Northwest Gastroenterology Associates permission to leave a message regarding my upcoming office visit, account/billing information, and or test results on the following: (Please check all that apply)

- Home ( )
Work ( )
Cell ( )
DO NOT LEAVE MESSAGE

I authorize Northwest Gastroenterology Associates to disclose information and or review my care with:

- Spouse (Name):
Other Family Member (Name): Relationship
Other (Name): Relationship

I authorize Northwest Gastroenterology Associates to obtain and share information with my pharmacy, escribe EMR solutions and other providers, as it relates to my medication history.

- Yes
NO

With my signature below, I acknowledge that this information will be kept in my medical record and the above parameters will be abided by until revoked in writing.

Signature of patient or patient's authorized representative Date signed

Relationship if signed by anyone other than patient

Northwest Gastroenterology Associates is actively involved in clinical research. Your physician may identify you as a possible clinical research candidate and you may be notified if you meet the criteria; however, your medical records will not be shared with a third party. At that time, you may elect to participate or decline.

Please indicate by initialing below if you consent to our office contacting you regarding clinical research participation. Indicating "I do" does not place you under obligation to participate in a clinical research study.

Please initial ( ) I do ( ) I do not



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The federal government is requiring that we ask you these questions.

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**What is your race? Please circle one:**

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander: \_\_\_\_\_

White/Caucasian

Multiracial

Other: \_\_\_\_\_

Decline to answer

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**What is your preferred language? Please circle one:**

American Sign Language

Mandarin - Cantonese

Mandarin - Chinese

English

French

Japanese

Korean

Russian

Somali

Spanish

Vietnamese

Other: \_\_\_\_\_

Decline to answer

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**Do you consider yourself to be of Hispanic or Latino ethnicity? Please circle one:**

Select one:    Yes    No    Decline to answer

# HEALTH HISTORY

Information provided will be held *STRICTLY CONFIDENTIAL*. Please complete front and back in full.

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Referring physician \_\_\_\_\_ Primary physician \_\_\_\_\_  
 Pharmacy name \_\_\_\_\_ Pharmacy number \_\_\_\_\_

**Why are you being seen today?** \_\_\_\_\_  
 \_\_\_\_\_

**Medications:** please list ALL including over the counter, vitamins and supplements. Include name, dose, and how often taken

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Medication allergies:** NO \_\_\_ YES \_\_\_      **Latex allergy:** NO \_\_\_ YES \_\_\_

If yes, please list \_\_\_\_\_  
 Reaction \_\_\_\_\_

**Medical history:** List hospitalizations, operations, serious illnesses or injuries

- |          |            |
|----------|------------|
| 1. _____ | date _____ |
| 2. _____ | date _____ |
| 3. _____ | date _____ |
| 4. _____ | date _____ |

**Family history:** List parents, brothers, sisters, or other relatives with significant medical history and/or cause of death, e.g. heart disease, cancer, diabetes, gastrointestinal problems, other

Relative	Age(s)	Significant medical problems	Cause of Death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			
Other			

**Other history:**

Describe any weight change over the past 1 month \_\_\_\_\_ 1 year \_\_\_\_\_  
 Are you on any special diet: low fat, vegetarian, low salt, other. Describe \_\_\_\_\_  
 Servings of dairy products consumed per day (milk, cheese, ice cream) \_\_\_\_\_  
 Servings of artificial sweeteners consumed per day \_\_\_\_\_  
 Servings of caffeine per day \_\_\_\_\_  
 Amount of alcohol per day \_\_\_\_\_  
 Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_  
 Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ Describe \_\_\_\_\_

ANY history of intravenous drug use, blood transfusions, blood exposure, sexual activity, travel, or employment which would put you at risk for hepatitis, AIDS, or unusual infections. If yes, describe \_\_\_\_\_  
 \_\_\_\_\_

**System review:** Please circle significant past or current medical problems or indicate NA if not applicable involving:

**general:** fever, fatigue, night sweats, other \_\_\_\_\_

**skin/head/eyes/ears/nose/mouth/throat:** changes in hair/nails or skin, rashes, hives, trouble with vision, glaucoma, cataracts, dizziness, deafness, sinus problems, hay fever, nosebleeds, sores in the mouth, dental problems, sore throat, hoarseness, other \_\_\_\_\_

**lungs/cardiovascular:** shortness of breath, wheezing, asthma, recurring bronchitis, emphysema, cough, chest pain, heart murmur or heart valve disease, irregular heart beat, high blood pressure, swelling, high cholesterol, other \_\_\_\_\_

**gastrointestinal:** difficulty swallowing, heartburn, nausea, vomiting, constipation, diarrhea, change in bowel habits, need for laxatives, bleeding, anemia, black tarry stools, abdominal pain, hemorrhoids, rectal problems, hepatitis, gallstones or gallbladder problems, liver or pancreas problems, other \_\_\_\_\_

**female:** irregular or painful menstrual cycle, endometriosis, pelvic infections, ovarian cysts, breast lump or discharge, breast pain, abnormal pap smear, menopause, sexually transmitted diseases, other \_\_\_\_\_

Date of last pap smear \_\_\_\_\_ Last mammogram \_\_\_\_\_

Birth control used \_\_\_\_\_ Could you be pregnant now \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of deliveries \_\_\_\_\_

Name of gynecologist \_\_\_\_\_

**male:** prostate problems, need to urinate frequently, night urination, impotence, vasectomy, sexually transmitted diseases, other \_\_\_\_\_

**urologic:** bladder or kidney infections, burning on urination, kidney stones, loss of urine with coughing or sneezing, other \_\_\_\_\_

**bones/joints/muscles:** arthritis, joint surgeries or replacements, swelling, back pain, other \_\_\_\_\_

**endocrine:** thyroid problems, diabetes, other \_\_\_\_\_

**neurologic/psychiatric:** migraine headaches, tension headaches, seizures, stroke, fainting, change in sensation, change in strength, paralysis, anxiety, depression, insomnia, excessive sleep, memory loss, schizophrenia, other \_\_\_\_\_

Do you have a living will, power of attorney, or other directives you would like us to know about? \_\_\_\_\_

Religion (optional) \_\_\_\_\_

Do you have any special questions or concerns? \_\_\_\_\_

**THANK YOU**

# Northwest Gastroenterology Associates

## Notice of Privacy Practices

**This Notice of Privacy Practices Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review it Carefully.**

### 1. Introduction

This Notice of Privacy Practices describes how we may use and disclose your protected health information ("PHI") to provide treatment to you; to seek payment for medical services you receive; and to support the legitimate health care operations of our practice.

"PHI" includes your demographic information such as name, address, telephone number and family; past, present and future information about your physical or mental health or condition; and information about the medical services provided to you, including payment information, if any of that information may be used to identify you.

The Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We may amend this Notice of Privacy Practices periodically and you may obtain a current copy of the Notice by contacting the office staff at any time.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice, the consent you have signed and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with our facility.

If you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer, Kim Snider, at 425-454-4768.

### 2. Safeguarding PHI Within the Office

We have in place appropriate administrative, technical and physical safeguards to protect the privacy of your PHI. We regularly train our staff on the obligation to protect the privacy of your PHI. We hold medical records in a secure area within the office. Only staff members who have a "need to know" are permitted access to your medical records and other PHI. Our staff understands the legal and ethical obligation to protect your PHI and that violation of this Notice or Privacy Practices will result in discipline in accordance with our personnel policy.

### 3. Uses and Disclosures of PHI Based Upon Your Written Consent

You signed our "Consent to Use and Disclosure of Protected Health Information" when you joined our practice. Based upon this consent, our practice will use and disclose your PHI for the following types of activities.

- **Treatment.** Treatment means the provision, coordination or management of your health care and related services by our facility and other health care providers involved in your care. It includes the coordination or management of health care by a provider with a third party, consultation between our practice and other

health care providers relating to your care or our practice's referral of you to a specialist physician or other practitioner or facility, such as a laboratory.

- Payment. Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management and collection activities. Payment also may include your insurance carrier's work in determining eligibility, claims processing, assessing medical necessity and utilization review.
- Health Care Operations. Health care operations mean the legitimate business activities of our medical practice. These activities include, for example, quality assessment and improvement activities; practitioner performance evaluation; fraud and abuse compliance; business planning and development; and business management and general administrative activities. For example, we may use a patient sign-in sheet at the front desk; we may call you by name in the waiting room when we are ready to serve you; and we may leave a reminder of your appointment on your answering machine or voicemail. We may also leave a message on your answering machine or voicemail with general medical information and may request for you to contact us for more detailed information. When we involve third parties, such as billing services, in our business activities, we will have them sign a "business associate" agreement obligating them to safeguard your PHI according to the same legal standards we follow. If we maintain a facility directory, we will include your name, a general statement about your condition, your religious preference and your location in the facility.
- Family and Close Friends Involved in Your Care. You have consented to disclosure of PHI that, in our judgment, is in your best interest to disclose to your family members and close friends who are involved in your health care.

#### **4. Uses and Disclosures of PHI Based Upon Your Written Authorization**

From time to time, you may request that our facility disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. These situations may include disclosures of sensitive PHI, such as HIV status or information about sexually transmitted diseases, mental health or psychiatric treatment, or substance abuse services. Also, you may authorize disclosures to individuals who are not involved in treatment, payment or health care operations, such as attorneys if you are involved in litigation either on your own or another's behalf. If you wish us to make disclosures in these situations, we will ask you to sign our "Authorization to Use and Disclose Protected Health Information.."

#### **5. Uses and Disclosures of PHI that are Permitted or Required by Law**

In some circumstances, we may use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization because it is in the best interest of our society at large that the use or disclosure of PHI be made in these situations.

- Emergencies. If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- Communication barriers. If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to the use and disclosure, we will make the use or disclosure.

- Required by law. We may disclose PHI to the extent required by law and in a manner limited to the specific requirements of the law.
- Public health activities. We may disclose your PHI to an authorized public health authority to prevent or control disease, injury or disability or to comply with state child or adult abuse or neglect law.
- Health oversight activities. We may disclose your PHI to a health oversight agency for audits, investigations, inspections and other activities necessary for the appropriate oversight of the health care system and the government benefits programs such as Medicaid and Medicare.
- Judicial and administrative proceedings. We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order expressly directing disclosure and within certain limits in response to a subpoena, discovery request or other lawful process.
- Law enforcement activities. We may disclose your PHI to a law enforcement officer for law enforcement purposes.
- Coroners, medical examiners and funeral directors. We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other lawful duties. We also may disclose your PHI to enable a funeral director to carry out his or her lawful duties.
- Research. We may disclose your PHI for certain medical or scientific research where the researchers have a protocol to ensure the privacy of your PHI.
- Serious threats to health or safety. We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- Armed forces personnel and national security. We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military command authorities to assure proper execution of the military mission. We also may disclose your PHI to certain federal officials for lawful intelligence, counterintelligence and other national security activities.
- Worker's compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with the Maine Workers' Compensation Act or other similar programs that provide benefits for work-related injuries or illness without regard to fault.
- You & DHHS. We must disclose your PHI to you upon request and to the Secretary of the U.S. Department of Health & Human Services to investigate or determine our compliance with the privacy laws.

## 6. Your Rights Regarding PHI

- Right to request restriction of uses and disclosures. You have the right to request that we not use or disclose any part of your PHI unless it is a use and disclosure required by law. Please advise us of the specific PHI you wish restricted and the individual(s) who should not receive the restricted PHI. We are not required to agree to your restriction request, but if we do agree to the request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. In that case, we will ask that the recipient not further use or disclose the restricted PHI.

- Right of access to PHI. You have the right to inspect and obtain a copy of your PHI in a "designated record set" (your medical and billings records) as long as we maintain the PHI in such a format. However, you do not have a right of access to psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative proceeding. Also, your right of access may be limited if providing certain PHI to you may endanger the health or safety of yourself or others. To request access to your PHI, please make your request in writing to our Privacy Contact. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. We have the right to charge a reasonable fee for providing copies of your PHI.
- Right to confidential communications. You have the right to reasonable accommodation of a request to receive communication of PHI by alternative means or at alternative locations. Please make your request in writing to our Privacy Contact. We will not require an explanation of your reasons for the request, but we will ask that you specify the alternative address or other method of contact and that you inform us of how payment for our medical services will be handled.
- Right to amend PHI. You have the right to request that we amend the PHI in your "designated record set" for as long as we maintain the PHI in such format. Please make your request in writing to our Privacy Contact. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement of reasonable length disagreeing with the denial and we have the right to submit a rebuttal statement. A record of any disagreement about amendment will become part of your medical records and may be included in subsequent disclosures of your PHI.
- Right to accounting of disclosures. Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those for treatment, payment or health care operations; to yourself; for a facility directory; to your family or close friends involved in your care; or for notification purposes. Please make your request in writing to our Privacy Contact. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with an accounting every 12 months free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.
- Right to copy of our Notice of Privacy Practices. We will ask you to sign a written acknowledgement of receipt of our Notice of Privacy Practices. We may periodically amend this Notice of Privacy Practices and you may obtain an updated Notice from our Privacy Contact at any time.

## 7. Complaint Procedure

- Within the facility. If you have a complaint about the denial of any of the specific rights listed in Section 6 above, about our Notice of Privacy Practices or about our compliance with state and federal privacy law, please make your complaint in writing to our Privacy Contact. We will respond to your complaint in writing within the timeframe listed in Section 6 above or in any case within 60 days of the date of your complaint.

- Outside of the facility. If you believe that we are not complying with our legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health & Human Services. You must make your complaint to the Secretary in writing within 180 days of the act or omission forming the basis of your complaint.

*This notice is effective 4/14/03.*