David S. James, D.O., F.A.C.G.

All information is strictly confidential. In order to serve you properly, we need the following information:

Patient's Name: _____
(Last) (First) (Middle) (Nickname)

Address: _____
(City) (State) (Zip)

Home Phone #: _____ Cell#: _____ Date of Birth: _____

Social Security #: _____ Male _____ Female _____ Age: _____
(Check One)

Circle One: Single Married Widow/ er Separated Divorced

EMPLOYMENT

Patient's Employer: _____ Position: _____

Business Address: _____ Business Phone: _____

Spouse's Name: _____ Spouse's Number: _____

MEDICAL

Chief Complaint / Reason for Visit: _____

Referring Dr. _____ Phone: _____

Emergency Contact: _____

Emergency Contact's Phone Number: _____

INSURANCE

Primary Insurance Company: _____

Policy / ID Number: _____

Secondary Insurance Company: _____

Policy / ID Number: _____

Subscriber Name: _____ **Social Security #:** _____ **Date of Birth:** _____

Signature: _____ Date: _____
(Patient, or Parent if patient is minor)

DAVID S. JAMES, D.O., F.A.C.G.
GASTROENTEROLOGY UNITED OF TULSA
3345 S. HARVARD / SUITE 301
TULSA, OK 74135
(918) 749-3399
FAX 747-5203

BOARD CERTIFIED
IN GASTROENTEROLOGY &
INTERNAL MEDICINE

OFFICE POLICIES AND PROCEDURES FOR GASTROENTEROLOGY UNITED OF TULSA, P.C.

Thank you choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment.

*All patients must complete our "Patient Information Form" before seeing the doctor.

*Full payment is due at the time of Service.

*We accept most insurance however, the portion not covered by your insurance is due at the time of service.

*There will be a $25.00 charge on all returned checks.

*We do offer an extended payment plan with prior credit approval.

*The physician-patient relationship may be terminated as a result of the patient and/or spouse, parent or guardian failing to meet their financial obligation to Dr. James.

*There is a $50.00 fee for appointments not cancelled with our office 24 hours in advance, this fee will not be covered by your insurance and will be billed to the patient.

Professional Fees:

All prices quoted are **ESTIMATES** only, not an exact price. The original procedure dollar amount does not normally include biopsies or photos. If either is required or requested, these will be charged as an additional amount.

Insurance:

As a **COURTESY** to you, we will file your insurance when you provide us with all insurance information and cards. Reasonable time will be spent on the filing of your claim but, after repeated tries to clear the account, the responsibility of payment will fall on the patient. If you have conventional insurance any deductible and/or co-pay must be paid at the time of service. If you are a member of a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) with which Dr. James has an in force contract, we will honor the agreement's participation requirements. You will, however be responsible for any co-pay required by your policy at the time of treatment.

Forms:

All forms that you may bring in to be filled out by your office will require that you allow us 72 hours for their completion before you come in to pick them up. A $25.00 service charge will also be required.

Medical Records:

You may obtain copies of your medical records however, you must **FIRST** complete a Release of Records form and then allow 72 hours before you can pick them up.

THANK YOU FOR UNDERSTANDING OUR OFFICE POLICIES AND PROCEDURES. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I have read and agree to the above office policies and procedures. I authorize the release of any information regarding my treatment to my insurance company, and I authorize the insurance benefits to be paid directly to Dr. David James D.O.

Signature_____Date_____

DAVID S. JAMES, D.O., F.A.C.G.
GREEN COUNTRY DIAGNOSTIC CENTER
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TULSA, OK 74135
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FAX 747-5203

BOARD CERTIFIED
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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, David S. James, D.O. originates and maintains medical and health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I further understand that this information serves as:

+a basis for planning my care and treatment
+a means of communication among the health professionals who contribute to may care
+a source of information for applying my diagnosis and treatment information to my bill
+a means for a third-party payer to verify that services were billed as actually provided
+and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a Patient Privacy Notice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Patient Privacy Notice prior to signing this consent. I understand that David S. James reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that David S. James is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you....that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Deficiency Syndrome (AIDS).

Information may be released to individuals/organizations for the indicated purpose, as outlined in the HIPAA Privacy Practices.

I acknowledge that I have received and read the HIPAA Notice of Privacy Practices for David S. James D.O./Gastroenterology United of Tulsa, P.C.

_____ April 14, 2003
Signature of Patient or Legal Representative Date Notice Effective

I acknowledge that I have received and understand the Consent to Use and Disclose Health Information provided by David S. James, D.O. office.

_____ _____
Signature of Patient or Legal Representative Date Signed

David S. James D.O. _____accepts _____denies _____accepts conditionally the restrictions imposed on release of information as stated above.

_____ _____
Signature/Title Date

HIPAA NOTICE OF PRIVACY PRACTICES

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

Who will follow this notice:
Any health care professional authorized to enter information into your file or record.
All employees, staff and other personnel.

We understand that medical information about your and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care. This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to: make sure that medical information that identifies you is kept private;
give you this notice of our legal duties and privacy practices with respect to protected medical information about you; and follow the terms of the notice that is currently in effect.

How we may use and disclose your medical information. Your protected health information may be used and disclosed without your authorization for the following purposes:

For Treatment: We may use your protected health information to coordinate and manage your health care and related services within David S. James D.O. and with others involved in your care. For example, this may include disclosing information to coordinate surgery or managing your care through a staff nurse or physical therapy provider.

For Payment: We may use and disclose protected health information in order to obtain reimbursement for your medical care. For example, David S. James D.O. may disclose your protected health in a bill to your health insurer so that the insurer will reimburse you or David S. James D.O. for the cost of the services provided..

Appointment Reminders and Treatment Alternatives: David S. James D.O. may use and disclose protected health information to contact you as a reminder that you have an appointment, also for treatment or medical care.

Health-related benefits and services: We may use and disclose protected medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals involved in your care or payment for your care: David S. James, D.O. may use and disclose your protected health information to notify or assist in notification of a family member or close personal friend involved in your care of your location, condition, or death, when directly relevant to such person's involvement with your care or payment related to your care, if you agree to such disclosure. If you are unable to agree because of either incapacity or an emergency situation, we may use or disclose your protected health information, that is directly relevant to your care, to a family member or close personal friend if David S. James determines it is in your best interest to do so.

Research: David S. James D.O. may use or disclose protected health information for research purposes if a waiver of individual authorization is approved by an applicable Institutional Review Board or privacy board and other requirements are met.

As required by law: We will disclose protected medical information about you when required to do so by federal, state or local law.

To avert a serious threat to health or safety: David S. James D.O. may use and disclose certain protected health 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 only be to someone able to help prevent the threat.

Special Situations
Organ and tissue donation: If you are an organ donor, David S. James D.O. may release protected health information to organ transplant or donation organizations to assist in organ, eye or tissue donation and transplantation.

Military and veterans: If you are a member of the armed forces, we may release protected medical information about you as required by military command authorities. We may also release protected medical information to a foreign military authority, if you are in their service.

Worker's compensation: David S. James, D.O. may release protected health information about you for workers' compensation as necessary to comply with workers' compensation laws and similar programs.

Public health risks: David S. James D.O. will disclose protected health information about you when needed to public health authorities authorized to collect such information, to a person who may have been exposed to a communicable disease, or to your employer in limited circumstances related to a work-related illness or injury or a workplace-related medical surveillance.

Health oversight activities: David S. James D.O. may disclose protected health information to a health oversight agency for activities authorized by law. For example, audits, investigations, inspections. These activities are necessary for the government to monitor health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes: If you are involved in a lawsuit or a dispute, David S. James D.O. may disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law enforcement: We may release protected medical information if asked to do so by a law enforcement official:
in response to a court order, subpoena, warrant, summons or similar process;
to identify or locate a suspect, fugitive, material witness, or missing person;
about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
to about a death we believe may be the result of criminal conduct;
about criminal conduct involving our practice; and
in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

About Deceased Persons: David S. James D.O. may release protected health information to a corner or medical examiner, to identify a deceased person or determine the cause of death. David S. James D.O. may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Your Rights Regarding Medical Information About you.
You have the following rights regarding protected medical information we maintain about you:

Right to inspect and copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes.

To inspect and/or copy your medical information you must submit your request to Cindy in our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. (By statue in Oklahoma we may charge you $0.25 per page for copies, plus our postage costs. If your record contains any item that requires a photographic process to copy, such as an x-ray or photograph, we may charge you up to $5.00 per image.)

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

To request an amendment, your request must be made in writing and submitted to Rhonda. In addition, you must provide a reason that supports your amendment 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:
was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
is not part of the medical information kept by our practice;
is not part of the information which you would be permitted to inspect and copy; or
in our judgment is accurate and complete as it appears or as it was ast the time it was originally captured and recorded.

Right to an accounting of disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures we have made of your medical information.

To request this list or accounting of disclosures, you must submit your request in writing to
Rhonda in our office. Your request must state a time period which may not be longer than six years and may not include dates before April 14,2003. Your request should indicate in what form you want the list (for example, on paper or electronically, i.e. on disk or by e-mail). The first list you request within each 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may chose to withdraw or modify your request at that time, before any costs are incurred.

Right to request restrictions: You have the right to request a restriction or limitation on the protected medical information we use or disclose about you for treatment, payment or health care operations. However, we must receive your restrictions in writing before we have made such disclosures. You also have the right to request a limit on the protected medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery to your family. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Rhonda in our office. In your request restrictions, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want limit to apply, for example, disclosures to your spouse.

Right to request confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, or at home, or by mail, or by phone. To request confidential communications, you must make your request in writing to Rhonda in our office. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a copy of this notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Rhonda Walden at 918-749-3399. All complaints must be submitted in writing.
You will not be penalized for filing a complaint.

Effective Date: April 14, 2003

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GASTROENTEROLOGY

HISTORY & PHYSICAL

Name _____ SS# _____ Date _____

Address _____ Occupation _____

Phone (home) _____ (work) _____ Date of birth _____ Age ____

Chief complaint _____

HISTORY OF PRESENT ILLNESS

DRUG ALLERGIES

CURRENT MEDICATIONS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Asthma	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Colon Cancer/Polyps	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑
Stomach/Ulcer	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ❑ Yes ❑ No Planning pregnancy? ❑ Yes ❑ No

MEDICAL HISTORY

❑ Scarlet fever _____ ❑ Heart palpitations _____ ❑ GI disorder _____
❑ Rheumatic fever _____ ❑ Arrhythmia _____ ❑ Renal disease _____
❑ Allergies/Hay fever _____ ❑ Orthopnea _____ ❑ Sexual dysfunction _____
❑ Diabetes _____ ❑ Congestive heart failure _____ ❑ GU disorder _____
❑ Alcoholism _____ ❑ Heart murmur _____ ❑ Menstrual dysfunction _____
❑ Fatigue _____ ❑ Hypertension _____ ❑ Venereal disease _____
❑ Dizziness/Fainting _____ ❑ Hyperlipidemia _____ ❑ Arthritis _____
❑ Shortness of breath _____ ❑ Claudication _____ ❑ Gout _____
❑ Asthma _____ ❑ Esophageal stricture _____ ❑ Stroke / TIAs _____
❑ COPD _____ ❑ Ulcer _____ ❑ Epilepsy _____
❑ Congenital heart disease _____ ❑ Liver disease _____ ❑ Anxiety _____
❑ MI _____ ❑ Gallbladder _____ ❑ Anemia _____
❑ Chest pain / Angina _____ ❑ Colon polyps _____ ❑ Endocrine disease _____

HABITS

❑ Smoke: Packs daily _____
How long _____
Interested in stopping? _____
❑ Exercise routine: _____
_____
❑ Contact with blood/bodily fluid at work: ____

❑ Coffee: Cups daily _____
Other caffeine _____
❑ Alcohol: Type _____
Amount _____
❑ Diet:
Salt intake _____
Fat intake _____

❑ Sleep: Difficulty falling asleep ____
Continuity disturbances ____
Snoring _____
Early morning awakening ___
Daytime drowsiness _____
Other _____

Name