MICHELLE RANDOLPH MD PC
2741 DEBARR Suite 402 ANCHORAGE AK 99508
(T)907-222-5077 (F)907-222-5088
WWW.AKGIMD.COM
Monday-Friday 8am to 4pm

PLEASE INCLUDE A COPY OF YOUR ID AND INSURANCE CARD (FRONT AND BACK) ALONG WITH THIS PAPERWORK. THANK YOU.

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PATIENT INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
SEX: ☐MALE ☐FEMALE	SSN:	DATE OF BIRTH:	MARITAL STATUS:
ETNICITY:		RACE:	
ADDRESS:			
PRIMARY PHONE NUMBER:		SECONDARY PHONE NUMBER:	
OK TO LEAVE DETAILED MESSAGE IN VOICE MAIL? ☐YES ☐NO			
EMAIL ADDRESS:		OK TO EMAIL TEST RESULTS? ☐YES ☐NO	
OCCUPATION:		EMPLOYER:	
PRIMARY CARE PROVIDER:		REFERRING PROVIDER:	
PREFERRED PHARMACY:		PHARMACY ADDRESS:	
HEALTH INSURANCE		☐ (SELF PAY)	
PRIMARY INSURANCE			
INSURANCE COMPANY:		SUBSCRIBER NAME:	
ID NUMBER:		GROUP NUMBER:	
EMPLOYER:	SUBSCRIBER DOB:	RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐PARENT	
SECONDARY INSURANCE			
INSURANCE COMPANY:		SUBSCRIBER NAME:	
ID NUMBER:		GROUP NUMBER:	
EMPLOYER:	SUBSCRIBER DOB:	RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐ SPOUSE ☐PARENT	
EMERGENCY CONTACT INFORMATION			
NAME:	RELATIONSHIP: ☐SPOUSE ☐PARENT ☐PARTNER ☐FRIEND	PHONE NUMBER:	

ALL CO-INSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING A REFERRAL FROM MY PRIMARY CARE PHYSICIAN IF ONE IS REQUIRED.
I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL ACCOUNT BALANCES OVER 30 DAYS. ANY ACCOUNTS THAT ARE REFERRED FOR COLLECTION WILL BE CHARGED REASONABLE COLLECTION FEES AND ATTORNEY FEES.
I AUTHORIZE THE DOCTOR TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I AUTHORIZE ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR.

_____ _____
PATIENT SIGNATURE DATE

CHIEF COMPLAINT:

☐ ABDOMINAL PAIN
☐ COLONOSCOPY SCREENING
☐ NAUSEA
☐ VOMITING
☐ STOMACH FULLNESS
☐ BLOOD IN STOOL
☐ LIVER DISEASE
☐ BLOATING
☐ FECAL INCONTINENCE
☐ CONSTIPATION
☐ HEARTBURN or REGURGITATION
☐ WEIGHT LOSS
☐ LOSS OF APPETITE
☐ ABNORMAL IMAGING (CT, ultrasound, xray)
☐ DIARRHEA
☐ DIFFICULTY SWALLOWING
☐ PAINFUL SWALLOWING
☐ ABNORMAL BLOOD TEST
☐ OTHER:
_____
_____

PLEASE DESCRIBE SYMPTOMS:

PREVIOUS TESTING- PLEASE INCLUDE DATES AND RESULTS IF AVAILABLE. PLEASE INCLUDE COPIES OF PREVIOUS UPPER ENDOSCOPY AND COLONOSCOPY REPORTS WITH PATHOLOGY RESULTS IF POSSIBLE

☐ BLOOD TEST
☐ CAPSULE ENDOSCOPY
☐ CT SCAN
☐ ENDOSCOPY
☐ COLONOSCOPY
☐ MRI
☐ STOOL TEST
☐ URINE TEST
☐ ABDOMINAL ULTRASOUND
☐ SIGMOIDOSCOPY
☐ NONE
☐ OTHER

CURRENT & PAST MEDICAL PROBLEMS

☐ ANXIETY/DEPRESSION
☐ ANESTHESIA COMPLICATION
☐ ASTHMA
☐ ATRIAL FIBRILATION
☐ CANCER. TYPE: _____
☐ CHRONIC BRONCHITIS/ EMPHYSEMA
☐ COLON POLYP
☐ CONGESTIVE HEART FAILURE
☐ CORONARY ARTERY DISEASE/ANGINA
☐ DIABETES MELLITUS
☐ DIVERTICULOSIS
☐ GERD (REFLUX)
☐ H. PYLORI/GASTRITIS
☐ HEMORRHOIDS
☐ HIGH CHOLESTEROL/ TRIGLYCERIDES
☐ HYPERTENSION
☐ IRRITABLE BOWEL SYNDOME
☐ KIDNEY STONE
☐ KIDNEY INSUFFICIENCY
☐ OSTEOPOROSIS/ OSTEOPENIA
☐ PEPTIC ULCER
☐ SEIZURE
☐ SHORTNESS OF BREATH
☐ SLEEP APNEA
☐ STROKE
☐ THYROID PROBLEM
☐ OTHER:

PAST SURGICAL HISTORY: ☐NONE

SURGERY:	DATE:	SURGERY:	DATE:
☐ APPENDECTOMY	_____	☐ INTESTINAL/ABDOMINAL	_____
☐ BREAST	_____	☐ TONSILLECTOMY	_____
☐ GALLBLADDER	_____	☐ STOMACH/DUODENAL ULCER	_____
☐ HERNIA REPAIR	_____	☐ OTHER	_____
☐ HYSTERECTOMY/OVARIES	_____		_____

HOSPITALIZATIONS OTHER THAN SURGERY

DETAILS	DATE

ALLERGIES TO MEDICATION – INCLUDE LATEX/TAPE, IODINE AND SERIOUS ADVERSE REACTIONS

MEDICATIONS	REACTIONS

CURRENT MEDICATIONS/SUPPLEMENTS INCLUDING OVER THE COUNTER MEDICATIONS

NAME	DOSE/FREQUENCY	NAME	DOSE/FREQUENCY

FAMILY HISTORY- INCLUDE AGE OF DIAGNOSIS

	FATHER	MOTHER	BROTHER	SISTER	GRANDPARENT
ESOPHAGEAL CANCER	☐	☐	☐	☐	☐
BREAST CANCER	☐	☐	☐	☐	☐
LIVER DISEASE	☐	☐	☐	☐	☐
GALLBLADDER DISEASE	☐	☐	☐	☐	☐
STOMACH CANCER	☐	☐	☐	☐	☐
SMALL BOWEL CANCER	☐	☐	☐	☐	☐
CELIAC DISEASE	☐	☐	☐	☐	☐
COLITIS/CROHN'S DISEASE	☐	☐	☐	☐	☐
COLON CANCER	☐	☐	☐	☐	☐
COLON POLYP	☐	☐	☐	☐	☐
UTERINE/OVARIAN CANCER	☐	☐	☐	☐	☐
RENAL/URETERAL CANCER	☐	☐	☐	☐	☐
OTHER	☐ EXPLAIN:				

SOCIAL HISTORY

SMOKING STATUS	☐ NEVER	☐ CURRENT/EVERY DAY	☐ CURRENT/SOME DAYS	☐ FORMER
ALCOHOL USE	☐ NO ☐ YES YEAR QUIT:_____	PER WEEK:_____	NUMBER OF YEARS:__	
RECREATIONAL DRUG USE	☐ NO ☐ YES YEAR QUIT:_____	DRUGS USED:_____		
MARITAL STATUS	☐ SINGLE	☐ MARRIED	☐ DIVORCED	☐ WIDOWED
CHILDREN	☐ NONE	☐ 1 CHILD	☐ 2 CHILDREN	☐ 3 OR MORE CHILDREN
EXCERCISE	☐ NO ☐ YES	TYPE:_____	FREQUENCY:_____PER WEEK	

ADDITIONAL SYMPTOMS

GASTROINTESTINAL
☐ ABDOMINAL PAIN
☐ BLOATING/GAS
☐ BLOOD IN STOOL OR ON TOILET PAPER
☐ CIRRHOSIS
☐ DIFFICULTY SWALLOWING
☐ FILLING UP QUICKLY AT MEALS
☐ FLUID IN ABDOMEN
☐ GALLSTONES
☐ HEARTBURN/REGURGITATION
☐ HEPATITIS A B C
☐ INTOLERANCE TO FOODS
☐ IRREGULAR BOWEL HABITS
☐ JAUNDICE
☐ LOSS OF CONTROL OF BOWELS
☐ MUCUS IN STOOL
☐ NAUSEA AND VOMITING
☐ PANCREATITIS

RESPIRATORY/LUNG
☐ ASTHMA
☐ DIFFICULTY BREATHING
☐ PERSISTENT COUGH
☐ RESPIRATORY COMPLICATIONS WITH SEDATION
☐ SLEEP APNEA/CPAP

ENDOCRINE
☐ DIABETES
☐ OSTEOPOROSIS OR OSTEOPENIA
☐ THRYOID DISEASE

NEUROLOGIC
☐ HEADACHES
☐ SEIZURES
☐ STROKES
☐ NUMBNESS
☐ WEAKNESS

SKIN
☐ ITCHING
☐ RASH
☐ UNUSUAL HAIR LOSS

CARDIOVASCULAR
☐ ABNORMAL HEART RHYTHM
☐ CHEST PAIN OR PRESSURE
☐ HIGH BLOOD PRESSURE
☐ SWELLING IN FEET OR LEGS
☐ CORONARY ARTERY DISEASE

GYNECOLOGY
☐ ENDOMETROSIS
☐ HEAVY PERIODS
☐ PREGNANT

PSYCHIATRIC
☐ ANXIETY
☐ DEPRESSION
☐ SUICIDE ATTEMPT

GENERAL
☐ DECREASED APPETITE
☐ FATIGUE
☐ FEVER
☐ CHILLS
☐ UNEXPECTED WEIGHT GAIN
☐ UNEXPECTED WEIGHT LOSS

EYES
☐ LOSS OF VISION

ENT
☐ HEARING LOSS
☐ TINNITUS
☐ SINUSITIS/SINUS DRAINAGE
☐ SORE THROAT
☐ HOARSENESS

RENAL/URINARY/KIDNEY
☐ PAINFUL URINATION
☐ NIGHTTIME URINATION
☐ RENAL FAILURE
☐ URINARY TRACT INFECTION

MUSCULOSKELTAL
☐ BACK/NECK PAIN
☐ JOINT PAIN/ARTHRITIS

BLOOD/LYMPH
☐ ANEMIA
☐ BRUISE EASILY
☐ PAST BLOOD TRANSFUSION
☐ SWOLLEN/TENDER LYMPH NODES

IS THERE ANYTHING ELSE THAT WE SHOULD KNOW:

MICHELLE RANDOLPH MD PC
NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT OF RECEIPT
EFFECTIVE OCTOBER 1, 2020

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.

This Notice describes the medical information practices of MICHELLE RANDOLPH MD PC. MICHELLE RANDOLPH MD PC is considered a covered entity, and therefore we are required by law to maintain the privacy of personal health information and to provide you with notice of our legal duties and privacy practices with respect to personal health information. All MICHELLE RANDOLPH MD PC departments or programs are covered by this Notice and your personal health information may be shared among these divisions.

Our Pledge Regarding Medical Information

We understand that medical information about your health is personal. We will not disclose your personal health information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the medical records we maintain. It describes the ways in which we may use and disclose medical information, and describes our obligations with regard to such information.

We are required by law to:

- Keep your protected health information private;
- Provide notice of our legal duties and privacy practices with respect to protected health information;

- Notify affected individuals following a breach of unsecured protected health information;
- Give you this Notice of Privacy Practices; and
- Follow the terms of the Notice of Privacy Practices currently in effect.

We have the right to change our practices regarding the personal health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling RACHELLE MELVIN, the Privacy Officer at 907-531-5213, or stopping by the Privacy Officer's office at 2741 DeBarr Road, Anchorage AK 99508.

How We May Use/Disclose Your Medical Information

The following are some of the different ways that we may use and disclose your personal health information:

For Treatment. We may use or disclose medical information about you to facilitate treatment, rehabilitation or treatment through services provided by MICHELLE RANDOLPH MD PC. For example, we may disclose medical information to other healthcare providers who are involved in taking care of you.

For Payment. We may use and disclose medical information about you to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies (either directly or through a third party billing company), medical necessity determinations and reviews, and collection of outstanding accounts.

For Health Care Operations. We may use and disclose medical information about you for other MICHELLE RANDOLPH MD PC health care operations necessary to run MICHELLE RANDOLPH MD PC. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; licensing; personnel training programs; fraud and abuse detection programs; and general MICHELLE RANDOLPH MD PC administrative activities.

To Business Associates. There are some services provided to MICHELLE RANDOLPH MD PC through contracts with business associates. Examples include

accounting, legal, training, and consulting services. Information shall be made available to business associates consistent with their need to know for purposes of providing services.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order.

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 another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Other Uses and Disclosures

We may also use and disclose your health information in the following circumstances, when permitted by law, and with only the minimum necessary information being disclosed:

- Appointment reminders
- Language interpreters
- Information about available treatments or products
- Funeral Directors/Coroners/State Medical Examiners
- Workers' Compensation
- Correctional Institutions (if you are in jail or prison)
- Law Enforcement
- Tissue and organ donation
- Disaster relief

- Military and Veterans (if you are an armed forces member)
- Responses to legally compliant court orders
- National security

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. This includes the use or disclosure of psychotherapy notes, the use or disclosure of PHI for marketing, or the sale of PHI, which will require your express written authorization.

Your Rights Regarding Personal Health Information

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to, or copies of, this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. If your records are held in electronic format, you may also obtain an electronic copy if it is reasonably available. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.
- **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. To request an amendment, your request must provide a supporting reason, be made in writing, and be submitted to the Privacy Officer. If we agree to amend the information, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We may deny your request for an amendment if does not meet the requirements listed above. In addition, we may deny your request if you ask us to amend information that: is not kept by or for MICHELLE RANDOLPH MD PC; 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 information which you would be permitted to inspect and copy; or is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request a list of disclosures, where such disclosure was made for any purpose other than treatment, payment or health care operations. We are not required to give you an accounting of information we have shared with our business associates or for which you have given us a written authorization. To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years or before April 14, 2003. Your request should indicate in what form you want the list (i.e. paper or electronic). The first list you request within a 12-month period will be free, and you may be charged for the cost of any additional lists. We will notify you of the cost and you may choose to withdraw or modify your request before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a transport or treatment we provided. <u>We are not required to agree to your request unless the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment purposes) and the information pertains solely to an item or service paid for fully out of pocket.</u>

  To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must describe: (1) what information you want to limit; (2) whether you want to limit use, disclosure or both; and (3) to whom the limits shall apply, for example, your spouse.

- **Right to Request Confidential Communications.** You can request that we communicate confidentially with you about medical matters. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will accommodate reasonable requests. Your request must specify how you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You may request a paper copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy.

Right to Revoke Authorization/Permissions

If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Your substance abuse records received by a person or entity pursuant to your written authorization may not be re-disclosed without your written consent.

Questions/Exercising Rights

If you have any questions about this Notice or would like to exercise any of the rights contained herein, please contact: RACHELLE MELVIN, Privacy Officer, 2741 DeBarr Road, Anchorage AK, 907-531-5213.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with MICHELLE RANDOLPH MD PC or with the Secretary of the Department of Health and Human Services. To file a complaint with MICHELLE RANDOLPH MD PC, contact the

Privacy Officer. All complaints must be submitted in writing. You will not be retaliated against or penalized for filing a complaint. The Secretary of DHHS can be reached at:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue. S.W.

Room 509F, HHH Building

Washington, D.C. 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received Notice of Privacy Practices and Client Rights, and that I understand and have had an opportunity to ask questions about the Notice.

_____ _____

Printed Name Date

_____ _____

Name of Parent/Guardian/Personal Representative Date