PATIENT REGISTRATION FORM

_____

Last Name First Name Middle Initial

_____

Address City State Zip Code

_____-_____-_____

Birth Date Gender Marital Status Social Security Number

_____

Home Phone Work Phone Cell Phone Email Address

_____

Language Race Ethnicity Parent/Guardian (If under 18 years old)

Notify in Emergency:

_____

Name Relationship Phone

Primary Care Physician: _____

Brief Summary of Problem: _____

_____

_____

PLEASE TAKE A MOMENT TO ANSWER THE FOLLOWING QUESTIONS
SO THAT WHEN THE DOCTOR SEES YOU THEY WILL BE ABLE TO EVALUATE YOU FULLY

Have you had any of the following tests, examinations or procedures performed that pertain to this visit? If yes, please tell us where this was performed and the approximate date.

PLACE & DATE (IF KNOWN)

1. EGD _____
2. Colonoscopy _____
3. Sigmoidoscopy _____
4. CT scan _____
5. Ultrasound _____
6. X-Ray _____
7. MRI _____
8. Bloodwork _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Pennsylvania Gastroenterology Consultants ("PGC") creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care.

I understand that this information is used as a means of communication among PGC personnel and with medical personnel outside of this practice.

I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients.

I have been provided an opportunity to review the Notice of Privacy Practices for the PGC that provides a more complete review of information uses and disclosures.

I understand that I have the right to review this Notice of Privacy Practices before signing this acknowledgment.

I understand that the PGC may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours at PGC's office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that the PGC is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of PGC and agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative Date Relationship to Patient

_____

Printed name of patient

Effective date April 14, 2003

AUTHORIZATION AND CONSENT TO TRANSMIT
VIA UNSECURED INTERNET AND TEXT MESSAGING

I consent to Pennsylvania Gastroenterology Consultants transmitting important information and messages, including billing information and appointment reminders containing the date, time, and location of my appointment, to me through electronic mail. I acknowledge that Pennsylvania Gastroenterology consultants does not have the capability to respond to my electronic mail transmissions through encrypted or otherwise secured Internet connections or text messaging. I waive any claims or rights with respect to transmission of ePHI or PHI via the unsecured Internet. I waive all rights, claims and damages relating to the negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against Pennsylvania Gastroenterology Consultants or any of its employees, agents, members or otherwise as a result of any third person improperly accessing, using or disclosing my appointment information as a result of transmission vis the unsecured internet or text messaging.

eMail: Yes_____ No_____

e-Mail Address: _____

text: Yes_____ No_____

Cell Phone #: (_____) _____

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient/Personal Representative/Relationship to patient Date

I grant Pennsylvania Gastroenterology Consultants permission to leave a message on my answering machine regarding my care, test results, treatment and diagnosis.

_____ Yes _____ No

I grant Pennsylvania Gastroenterology Consultants permission to leave information regarding my medical care, test results, treatment and diagnosis with the family member I have listed below.

_____ Yes _____
(Name and relationship of family member)

ADVANCE DIRECTIVES

The Pennsylvania Living Will Law is the legal authority which allows Health care providers to provide a statement of limitations as to why they cannot implement an Advance Directive. This facility does not honor Advance Directives for any patient who is having a procedure (regardless of known medical conditions or the procedure type) on the basis of conscience. Conscientious objection is allowed under the law.

If you have a procedure done in this facility and you sign an informed consent, in the unlikely event of an emergency, the facility will always attempt to resuscitate a patient and measures will be taken to maintain health and transfer the patient to a higher level of care (hospital) in the event of deterioration.

PA State law requires that the facility have a copy of the document on file EVEN if the facility is unable to comply with the Advance Directive based on the limitations stated above.

PATIENT RESPONSIBILITIES

1. You have a responsibility to tell us of any current executed Advance Directive.

2. You have a responsibility to provide us with current information including a copy of any executed Advance Directive/Healthcare living will or Power of Attorney for healthcare.

PA State Health Regulations state that:
In Pennsylvania, capacitated adults have the right to decide whether to accept, reject or discontinue medical care and treatment. There may be times, however, when a person cannot make his or her wishes known to a medical provider. For example, a person may be incompetent, in a terminal condition or in a state of permanent unconsciousness, and unable to tell his or her doctor what kind of care or treatment he or she would like to receive or not to receive. This can be addressed through an advance directive. An advance directive is a written document that you may use, under certain circumstances, to tell others what care you would like to receive or not receive should you become unable to express your wishes at some time in the future. Advance directives may take many forms, and are commonly referred to as a "living will". In Pennsylvania, a living will is known as an advance directive for health care.
The living will, or advance directive for health care declaration, becomes operative when:

- Your doctor has a copy of it; and
- Your doctor has concluded that you are incompetent and you are in a terminal condition or in a state of permanent unconsciousness.
- Pennsylvania's living will law states that you may revoke a living will at any time, and in any manner. To revoke a living will you must tell your doctor or other health care provider that you are revoking it. Someone who saw or heard you revoke your declaration may also tell your doctor or other health care provider.

Your doctor or any other health care provider must inform you if they cannot in good conscience follow your wishes or if the policies of the health care provider prevent them from honoring your wishes. That is one reason why you should give a copy of your living will to your doctor or to those in charge of your medical care and treatment. The doctor or other health care provider who cannot honor your wishes due to conscientious objection must then help transfer you to another health care provide willing to carry out your directions — if they are the kind of directions which Pennsylvania recognizes as valid.
There is no single correct way to write a living will or declaration. Your living will is not valid unless signed. If you are unable to do so, you must have someone else sign it for you; and two people who are at least 18 years old must sign your living will as witnesses. Neither of those witnesses may be the person who signed your living will on your behalf if you were unable to sign it yourself. It is suggested that you also date your living will, even though the law does not require it. In Pennsylvania, you are not required to have your living will notarized; however, if you are contemplating using the document in another state, you should find out if the other state requires notarization.
Any capacitated person may make a living will who is at least 18 years old, or is a high school graduate, or has married may make a living will.

PLEASE BRING THIS COMPLETED DOCUMENT TO YOUR APPOINTMENT

Digestive Disease Institute
899 Poplar Church Road
Camp Hill, PA 17011

Policy on Advance Directives:

As a patient of Digestive Disease Institute, a patient has the right to have informed decisions regarding their Advance Directives for health care ON file. Patients may obtain forms and a copy of the PA State information regarding Advance Directives from the administrator, or any employee. Please note this facility DOES NOT recognize (implement) executed Advance Directives on the basis of conscience, as permitted by PA State health and safety Living Will Law. In the unlikely event of an emergency, the facility will always attempt to resuscitate and transfer to a higher level of care (hospital) in the event of deterioration.

Although this institution does not honor Advance Directives, the PA Department of Health still REQUIRES the facility to obtain this information for your medical records. You will be asked if you have a "Living Will", have assigned a "Healthcare Power of Attorney", or designated a "surrogate" to act on your behalf. Please complete this information and acknowledge your response by signing below. It is the patient's / designee's responsibility to supply a copy of the current executed Advance Directive to the facility. Please bring this with you the day of procedure and give it to the receptionist upon registration

____ I have a Healthcare Living Will _____
(state location, if possible)

____ I have a Health Care Power of Attorney _____
(designee, if available)

____ I have designated a" Surrogate" listed for the above _____
(name of surrogate)

___ I have none of the above

_____ _____ _____
Patient Signature Witness Signature Date

_____ _____ _____
Printed Name Printed Name Date