MANHATTAN GASTROENTEROLOGY

170 East 78th Street
New York, NY 10075

P: 212-427-8761
F: 212-427-8762
www.citygastro.com

DATE: ______________________ **PLEASE PRINT CLEARLY**

I. **Demographics:**

PATIENT NAME: ________________________________ **SOCIAL SECURITY#** ______________________

DATE OF BIRTH: ____/____/____ **Age:** ____ **GENDER:** M☐ F☐ **MARITAL STATUS:** Married Single Divorced Widowed

PATIENT'S ADDRESS: ____ **Apt:** __________

City: ____________________ **State** __________ **Zip** __________ **Email:** ______________________

WORK PHONE #: ____________________ HOME #: ______________________ **CELL #** ______________________

Occupation: ______________ **Employer:** ____

How did you hear of us? ☐ Referring Doctor ☐ Zoc Doc ☐ Yelp ☐ Internet ☐ Other ____________________________

Referring Physician/Whom Referred you: ____

Doctor's name, Address, Phone and# Fax# where you would like your medical info to be sent: ______________________

____

In case of emergency please notify: ______________________________________ ph. # ______________

II. **Medical History:** ____

____

Gastrointestinal history:

☐ Anemia
☐ Anxiety/Depression
☐ HIV/AIDS
☐ Blood Clots
☐ Cancer
☐ Diabetes
☐ Heart Problems
☐ High Blood Pressure
☐ Seizures
☐ Kidney Problems
☐ Liver Problems
☐ Lung Problems
☐ Abdominal Pain
☐ Pancreatitis
☐ Crohn's/Ulcerative
☐ Diarrhea
☐ Heartburn
☐ Liver Dis/Hepatitis
☐ Irritable Bowel
☐ Polyps
☐ Rectal Bleeding
☐ Trouble wallowing

B. **Past Surgeries or prior Hospitalizations:** ____

____

D. **Current Medications:** (including over-the-counter, prescription, birth control pills):

1.______________ 2.______________ 3.______________ 4.______________
5.______________ 6.______________ 7.______________ 8.______________

E. **Allergies:** ____

F. **Please explain briefly why you are here today:** ______________________________________

____

____

MANHATTAN GASTROENTEROLOGY

170 East 78th street
New York, NY 10075
P : 212-427-8761
F : 212-427-8762
www.citygastro.com

NOTICE OF PRIVACY PRACTICE

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We understand your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this official notice of our practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of the Notice of Privacy currently in effect and to provide notice of its legal duties and privacy practice with respect to the protected health information.

Prior to making important changes to our privacy practice, we will make available on request a revised Notice of Privacy Practices.

This notice will be followed by any health care professional authorized to enter information in your medical record. All employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, site and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment: We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for specific condition, we may need to know if you are allergic to specific drugs that could influence which medications we prescribe for the treatment purpose.

For Payment: We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from your insurance, third party or you. Example: We may need to send your protected health information, such as your name, address, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures that Can Be Made Without Consent or Authorization

- As required during an investigation by Law enforcement agencies.
- To avert a serious threat to public health safety.
- As required by military command authorities for their medical records.
- To workers' compensation or similar programs for processing of claims.
- In response to legal proceeding.
- To a coroner or medical examiner for identification of body.
- If an inmate, to the correctional institution or law enforcement official.
- As required by the US Food and Drug Administration (FDA).
- Other healthcare providers treatment activities.
- Other covered entities= healthcare operations activities (to the extent permitted under HIPPA).
- Uses and disclosures required by law.
- Uses and disclosures in domestic violence or neglect situations.
- Health oversight activities.
- Other public activities.
- We may contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

Patient's Name:____ Date of Birth:_________

I understand that, under The Health Insurance Portability Accountability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practices.

Dr. Shawn Khodadadian reserves the right to change the terms of the Notice of Privacy Practices. I understand the Practice will provide me with a copy of its Notice of Privacy Practices on request.

Patient's Signature:___________________________________ Date:_____________.

I give permission to Dr. Shawn Khodadadian and his staff to leave a message on my automated answering device or to family member regarding results of any test or appointments that were done in this office and/ or referred by this office.

X____

(Signature of Patient, parent or guardian) (Date)

If a personal representative on behalf of the patient signs this consent, complete the following:

____

(Parent/ Guardian's Name) (Relationship) (Date)

MANHATTAN GASTROENTEROLOGY

170 East 78th Street
New York, NY 10075

P : 212-427-8761
F : 212-427-8762
www.citygastro.com

Assignment of Benefits

I understand that I am financially responsible to Dr. Shawn Khodadadian for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill as determined by the office of Dr.Khodadadian and /or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that the provider may not be in network with my plan and that I am responsible for all charges as stipulated above. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products received.

In Certain Circumstances, an insurance company may send for services provided by Dr. Khodadadian to the patient. In some cases, the patient agrees to endorse and send such check to Dr.Khodadadian. If the patient deposits such check into a personal account, the patient agrees to send the a check for the equivalent amount to our office. If the patient receives an Explanation of Benefits (EOB) from an insurance company, the patient agrees to send a copy of the EOB directly to us.

______________________________ Signature of Insured

______________ Date

MEDICARE PATIENTS ONLY: I request that payment of authorized MEDICARE BENEFITS be made either to me or on my behalf to Dr. Shawn Khodadadian for services furnished to me by the provider. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for related services.

______________________________ Signature of Insured

______________ Date