Brian F. Sweeney Jr. MD
Gastroenterology
4048 Laurel St, STE 301 Anchorage, AK 99508

Phone: (907)562-2928 Fax: (907)563-4848

Email: akgastro@akgastro.com

Patient Full Name: _____

Date of Birth: _____/_____/_____ Sex: M □ F □

Marital Status: S □ M □ D □ SSN: _____/_____/_____

Spouse's Name: _____ Spouse's Date of Birth: _____

***If the Patient is in the Military or a Military dependent**

*Spouse's SSN: _____/_____/_____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Employer: _____

Ethnicity:

□American Indian/Alaska Native □Unknown □Asian □Hispanic/Latino □Other
□White Non-Hispanic □Black or African American □PT Decline to Provide
□Pacific Islander/Native Hawaiian

Mailing Address: _____

City: _____ State: _____ Zip code: _____

The <u>Home Address Section</u> does not need to be completed if the Mailing Address is the same

Home Address: _____

City: _____ State: _____ Zip code: _____

Patient Signature: _____ Date: _____

Insurance Information:

Billing is a courtesy we offer free of charge to our patients and in now way relieves them of their financial responsibility

(1ST) Primary Insurance Carrier: _____

Insurance Holder's Name: _____ Date of Birth: _____

Relationship to Insured: Self □ Spouse □ Other: _____

ID Number: _____ Group Number: _____

(2nd) Secondary Insurance Carrier: _____

Insurance Holder's Name: _____ Date of Birth: _____

Relationship to Insured: Self □ Spouse □ Other: _____

ID Number: _____ Group Number: _____

(3rd) Tertiary Insurance Carrier: _____

Insurance Holder's Name: _____ Date of Birth: _____

Relationship to Insured: Self □ Spouse □ Other: _____

ID Number: _____ Group Number: _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR OTHER INSURANCE COMPANY BENEFITS BE MADE TO BRIAN F. SWEENEY JR, MD ON MY BEHALF, FOR ANY SERVICES FURNISHED TO ME BY BRIAN F. SWEENEY JR, MD, REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. I AUTHORIZE BRIAN F. SWEENEY JR, MD, TO RELEASE ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER FOR THE PROCESSING OF ALL MEDICAL CLAIMS FILED ON MY BEHALF.

I UNDERSTAND THOSE CHARGES THAT ARE NOT COVERED BY MY INSURANCE ARE MY OWN RESPONSIBILITY.

Patient Signature: _____ Date: _____

Medical History Intake:

Reason for Visit: Colonoscopy □ Endoscopy □ Other/Additional Symptoms: _____

_____

Please Circle Any Current or Recent (Within the Last 6 months) Medical Problems You Have:

General:

Covid- 19 Diabetes I Diabetes II Chronic Fatigue Weight Gain
Fever Chills Night Sweats Easy Bruising Depression
Nervousness High Cholesterol

Urinary:

Blood in Urine Kidney Stones Painful Urination Urination at Night
Kidney Disease

Bones/Joints:

Arthritis Back Pain Gout Osteoporosis

Skin:

Rashes Hives

Heart:

Chest Pain Swollen Ankles Irregular Pulse Leg Pain High Blood Pressure
Heart Disease Pacemaker

Neurologic:

Stroke Tremors/Shakiness Numbness/Tingling Headaches Memory Loss

Lungs:

COPD (Chronic Obstructive Pulmonary Disease)

Ear, Eyes, Nose:

Ringing in Ears Ear Infections Dizzy Spells Sinus Problems Vision Problems
Hoarseness

Please List Any Additional Medical Problems:

_____ _____

_____ _____

Please List Any Prior Hospitalizations, Surgeries, Endoscopies, & Colonoscopies: □ None

_____ _____

_____ _____

Please Provide a Separate List or Write Down Your Current Medications: □ None

_____ _____

_____ _____

_____ _____

Are you currently taking Ozempic, Rybelsus, Trulicity or Mounjaro? □ Yes □ No

List Any Medicine Allergies:
□ None

_____ _____

Do You Smoke? □ Yes □ No Do You Drink Alcohol? □ Yes □ No

If Yes, How Long? _____ If Yes, How Often? _____

Year Quit: _____ If Yes How Much? _____

Do You Use Marijuana or Any Other Recreational Drugs? □ Yes □ No
If Yes, How Often? _____

Please List the Member of Your Immediate Family (Parents, Siblings, or Children) That Have Any of the Following Conditions:

Colon Cancer: _____ Heart Disease: _____

Colon Polyps: _____ Pancreatitis: _____

Cirrhosis: _____ Hepatitis A □ B □ or C □ _____

Ulcerative Colitis: _____ Stomach Disease: _____

Crohn's Disease: _____ Other Cancers: _____

Please Circle if You Currently Have or Have Had (In the Last 6 months) Any of the Following Gastrointestinal Issues?

Abdominal Pain Heartburn Nausea Vomiting Anemia Crohn's Disease

Liver Disease Pancreatitis Cirrhosis Eating Disorder(s) Ulcerative Colitis

Trouble Swallowing Black Stools Constipation Weight Loss Hepatitis A □ B □ C □

Blood in Stool Diarrhea Jaundice Regurgitation History of GI Cancer(s)

BRIAN F. SWEENEY JR. MD
4048 LAUREL ST. SUITE 301 ANCHORAGE, AK 99508
PHONE (907)562-2928 FAX (907) 563-4848

YOUR RIGHT TO PRIVACY

PLEASE PRINT PATIENT'S NAME:_____

WE UNDERSTAND YOU MAY HAVE CONCERNED RELATIVES OR SIGNIFICANT OTHERS. PLEASE LIST NAMES OF THOSE PEOPLE THAT WE MIGHT SHARE YOUR MEDICAL INFORMATION WITH. WITHOUT YOUR WRITTEN CONSENT, THIS INFORMATION WILL NOT BE RELEASED.

NAME:_____ PHONE: _____

RELATIONSHIP:_____

NAME:_____ PHONE: _____

RELATIONSHIP: _____

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By my signature above, I acknowledge that I have received BRIAN F. SWEENEY JR MD PC Notice of Privacy Practices and Client Rights, and that I understand and have had an opportunity to ask questions about the Notice.

This acknowledgement page should be retained in patient's record. If acknowledgement could not be obtained from patient, the reasons must be documented below.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

DO YOU HAVE A DURABLE P.O.A ON FILE? □ Y / □ N

IF YES, PLEASE ATTACH A COPY: o COPY ATTACHED (Legal documentation is required for those who hold power of attorney)

Definition: A "durable power of attorney for health care" is the designation of an agent to make current health care decisions for you.

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LIFETIME MEDICARE SIGNATURE ON FILE

***This page will only need to be completed if you have Medicare**

_____ _____

Patient Name: Medicare ID Number:

- I am giving Brian F. Sweeney Jr. MD permission to ask for Medicare payments for my medical care.
- I understand that Medicare needs information about me and my medical condition to make decision about these payments. I give permission for my information to be released to Medicare and companies that handle Medicare payment requests.
- I understand that the Centers for Medicare and Medicaid Services (formerly HealthCare Financing Administration) is the government Medicare agency.
- I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.
- In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____ Date: _____

Telemedicine Informed Consent for Brian F. Sweeney Jr, MD

Telemedicine involves the use of electronic communications to enable healthcare providers and patients at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her local healthcare site (i.e. home) while the physician consults and obtains test results at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a specialist.

Possible Risks:

As with any medical visit, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the consultant may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this document, you acknowledge that you understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand the alternatives to telemedicine consultation, including an in-person visit, have been explained to me. In choosing to participate in a telemedicine consultation, I understand that some parts of
4. the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting healthcare provider.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

Patient Consent to The Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I have read this document carefully (both pages), and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telemedicine visit under the terms described herein.

Patient Signature: _____ Date: _____

Medical Procedure Cancellation Policy

Our policy is as follows:

We please ask that you give our office a 3-business day notice in the event you need to reschedule your procedure(s) with the Physician. This allows other patients to be scheduled in that appointment slot. It also makes it possible to reschedule your appointment more efficiently.

Also, if a patient misses a procedure without contacting our office, this is considered a missed appointment.

If either of these situations occur, a fee if $100.00 will be charged to your account. This fee must be paid before we will be able to reschedule your procedure.

I **have read and understand the Medical Procedure Cancellation policy of the practice and agree to be bound by the terms.**

Patient Signature: _____ Date: _____

BRIAN F. SWEENEY JR MD PC

NOTICE OF PRIVACY PRACTICES EFFECTIVE SEPTEMBER 1, 2013

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 of Privacy Practices ("Notice") describes the medical information practices of BRIAN F. SWEENEY JR MD PC. are considered covered entities, and therefore 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 of BRIAN F. SWEENEY JR 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 and follow the terms of the Notice 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 the Privacy Officer at 907-562-2928, or stopping by the Privacy Officer's office at 4048 LAUREL STREET, SUITE 301, ANCHORAGE, ALASKA 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 BRIAN F. SWEENEY MD PC For example, we may disclose medical information to other healthcare providers who are involved in taking care of you.

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 inwriting, 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 BRIAN F. SWEENEY 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. 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

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: Privacy Officer, 4048 LAUREL STREET, SUITE 301, ANCHORAGE ALASKA, 99508.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with BRIAN F. SWEEN EY JR MD PC or with the Secretary of the Department of Health and Human Services. To file a complaint with BRIAN F. SWEENEY JR 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. 2020