ESSEX-HUDSON
GASTROENTEROLOGY
SPECIALISTS IN GASTROENTEROLOGY AND LIVER DISEASES

5 Franklin Avenue, Suite 109
Belleville, NJ. 07109
Phone 973-759-7240 Fax 973-759-7243

Robert Spira, MD | Joseph DePasquale, MD| Etan Spira, MD | Youssef Botros, MD

NEW PATIENT PAPERWORK INSTRUCTIONS

Please be sure to have these items with you on the day of your appointment:

- Photo ID (ex: Driver's License, Passport)
- Insurance Card
- Referral if needed *(Please check with your primary physician or insurance company – **if required by your insurance company*** **YOU CANNOT BE SEEN WITHOUT IT.**
- Any records pertaining to your visit (ex: bloodwork, radiology, and records from any previous procedures)
- All required paperwork completed:
    - Registration Form
    - Health History Questionnaire
    - Notice of Privacy Practices Acknowledgement Form
    - Consent for Use and Disclosure Form
    - Communication with Family/Caregivers Form

If you have any questions, please feel free to contact us.

Thank You

Essex Gastroenterology Associates

5 Franklin Avenue, Suite 109
Belleville, NJ 07109
Phone: 973-759-7240
Fax: 973-759-7243

Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**Birthdate:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Referring doctor:			
Current Occupation:			

PERSONAL HEALTH HISTORY

Reason for your visit today:

Please indicate if you are having any *current* problems or symptoms in the following areas:	☐ Eyes	☐ Muscular
	☐ Skin	☐ Joints
	☐ Ears, Nose, Throat	☐ Bones
	☐ Stomach/Digestion	☐ Neurological
	☐ Lungs/Breathing	☐ Allergies
	☐ Heart	☐ Reproductive
	☐ Circulation	☐ Thyroid/Endocrine
	☐ Blood	☐ Psychiatric
	☐ Lymph	☐ Urinary

List any medical problems that other doctors have diagnosed:

Surgeries/Hospitalizations

Year	Reason	Hospital

Please go to page 2

List current medications (include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers):		
Name of Drug	**Strength/Dose**	**Frequency Taken**

Allergies to medications ☐ **No** ☐ **Yes (if yes, indicate below)**	
Name of Drug	**Reaction You Had**

Please go to page 3

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Women Only	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	Are you pregnant?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you or any family member have a history of any of the following:		
Cancer If yes, indicate site:	☐ **Yes**	☐ **No**
Heart Disease (Heart Attack/Heart Failure)	☐ **Yes**	☐ **No**
High Blood Pressure	☐ **Yes**	☐ **No**
Stroke	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**
Other:		

PATIENT SIGNATURE:

Date:

REGISTRATION FORM

ESSEX GASTROENTEROLOGY ASSOCIATION
5 Franklin Avenue - Suite 109, Belleville, NJ 07109
Phone: 973-759-7240 Fax: 973-759-7243

Today's date:_____

PATIENT INFORMATION

Patient's Last name: First: Middle:					Social Security #:		Marital status (circle one) Single / Mar / Div / Sep / Wid	
Race/Ethnicity: ❑ White ❑ Asian	❑ American Indian	❑ African American	❑ Hawaiian/Pacific Islander	❑ Hispanic		Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:					Home phone no.: ( )		Cell phone no.: ( )	
City:	State:	ZIP Code:		E-Mail:				
Occupation:	Employer:						Employer phone no.: ( )	
Work Address/City/State/Zip Code:								
Primary Doctor:					Phone no.: ( )			
Address/City/State/Zip Code:								
Referring Doctor:					Phone no.: ( )			
Address/City/State/Zip Code:								
Pharmacy Name:					Pharmacy Phone Number:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Name:		Policy Number:	
Name of Subscriber:			Birth date: / /
Secondary Insurance Name:		Policy Number:	
Name of Subscriber:			Birth date: / /
Guarantor's Name: (If other than Patient)			
Name of Subscriber:	Subscriber's Social Security #:		Birth date: / /

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Address/City/State/Zip Code:			

I authorize Dr. _____to furnish information to insurance carriers concerning my illness and treatment, and I assign the physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

_____ _____

Patient/Guardian signature *Date*

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Robert Spira, MD | Joseph DePasquale, MD| Etan Spira, MD | Youssef Botros, MD

Effective Date: AUGUST 15, 2005

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY ESSEX-GASTROENTEROLOGY ASSOCIATES, LLC, dba ESSEX-HUDSON GASTROENTEROLOGY, ITS MEMBERS, ROBERT S. SPIRA, M.D. AND JOSPEH R. DEPASQUALE, M.D., ITS FUTURE MEMBERS AND ITS STAFF ("THE PRACTICE," "US" OR "WE") AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice applies to all practice locations of Essex Gastroenterology Associates, LLC (Jersey City, Newark, and Belleville, New Jersey). If you have any questions about this notice, please contact our Privacy Officer at the telephone number and address of our main office set forth above.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to promoting the confidentiality of medical information about you. We create a record of the care and services you receive at this office, and we need this record to treat you and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office, whether made by your personal doctor or by other personnel within our office.

This notice advises you about the ways in which we may use and disclose medical information about you. It also describes your rights, as well as certain obligations that we have regarding the use and disclosure of medical information.

We are required by law to:

- safeguard your protected health information (PHI or "health information") as required by law;
- give you this notice of our legal duties and privacy practices and
- use and disclose your PHI consistent with the Notice of Privacy Practices that is in effect at the time of any use or disclosure.

CONSENT FOR USE AND DISCLOSURE

The first time you come to our office, We will ask you to sign a "Consent for Use and Disclosure." This consent will grant us permission to use Your health information for the purpose of this Practice's and other health providers' and health insurers treatment, payment and certain healthcare operations as further described below. Treatment, payment, and healthcare operations are sometimes referred to as "TPO." The "Consent for Use and Disclosure" will also permit Us to include in the health information that We use and disclose for TPO any of your health care records concerning AIDS/HIV infection, your mental health, any communicable diseases including, but not limited to tuberculosis and venereal disease, and any alcohol, drug, or other substance abuse and treatment, but not genetic testing. You are required to sign the "Consent for Use and Disclosure" as a condition of treatment by us. With respect to genetic information, such as obtaining a DNA sample, We will not obtain, retain, use or disclose genetic information about you without obtaining a separate consent from you for those purposes. Any further use or disclosure of your health information will be made only pursuant to your Authorization, a Court Order or as otherwise required or permitted by law.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that We may use and disclose medical information. For each category of uses or disclosures, We will explain what We mean and provide examples. Not every use or disclosure in a category will necessarily be listed below. However, all of the ways which We are permitted to use and disclose information will fall within one of the categories.

Treatment - We may use medical information about you to provide you with medical treatment or services. We may also disclose information about you to this Practice's personnel, including nurses, doctors, technicians and receptionists, and to people outside of this office, including other doctors, health care facilities and their personnel, who may be involved in your treatment or assist others in their treatment of you. For example, we may use information from tests that we order to diagnose your problem. We may also use and disclose information about you to coordinate care or to provide a prescription. We may also disclose information about you to another doctor to whom we may refer you to assist that doctor in his or her diagnosis or treatment. We may also disclose information about you to your family members and your close personal friends who are involved in your care.

Payment - We may use and disclose medical information about you so that the treatment and services which We provide to you at the office, hospital, ambulatory surgery center, nursing home or other site may be billed to and payment may be collected from you and/or your insurance company or other responsible third party, including a family member. For example, We may need to provide to your health insurance plan information about the services that We provided to you at the office, hospital or ambulatory surgery center, so that your health plan will pay Us or reimburse you for the services. We may also tell your health insurance plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose information about you to other health providers and healthcare facilities to assist them in their billing and collection efforts.

Health Care Operations - We may use and disclose medical information about you for our office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. For example, We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many office patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other office personnel for review and learning purposes. We may also combine the medical information. We have with medical information from other offices to compare how We are doing and see where We can make improvements in the care and services that We offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of our patients.

Appointment Reminders, Test Results, Responding to Phone Calls - We may contact you by mail or phone (including leaving voice mail messages or messages with household members) in an effort to provide appointment reminders or test results or in response to calls that you placed to Us. You have the right to request to receive communications regarding your personal health information from Us by alternative means or at alternative locations. For instance, you may request that appointment reminders or test results not be left on voice mail or sent to a particular address. We will accommodate reasonable requests. However, we may condition the accommodation of your request on your providing an alternative method of or location for contact. If the accommodation may impact our ability to secure payment, we may also condition the accommodation on satisfactory receipt of information as to how payment will be handled. Requests for alternate methods of communication must be made in writing and addressed to the Practice's Privacy Officer at the address listed on the first page of this notice.

Disclosures to Family and Friends - Unless you object and direct us otherwise, We may disclose health information about you to family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and We determine that a disclosure may be in your best interest, We may share health information with such individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. Any objections you may have to such disclosures must be made in writing and addressed to our Privacy Officer at the address listed on the first page of this notice.

Treatment Alternatives - We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. For example, we may use your information to determine whether you qualify for a nutritional counseling program.

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

OTHER USES AND DISCLOSURES

Research - Under certain circumstances, We may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before We use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the office. We will ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

With your Written Authorization – We may release medical information about you pursuant to and in accordance with your written authorization. You have the right to revoke Your authorization provided We have not taken action in reliance on the authorization. Your revocation must be in writing and addressed to our Privacy Officer at the address listed on the first page of this notice.

As Required by Law - We will also use your healthcare information whenever such use or disclosure is required by federal, New Jersey or local law. Such disclosures might include (but not be limited to) mandatory reporting (of certain diseases, wounds, deaths), and disclosure to the federal government to ensure that we are in compliance with the federal privacy laws.

As Permitted by Law without your Authorization As Follows:

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

Organ and Tissue Donation - If you are an organ donor, We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans - If you are a member of the armed forces, We may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

If you are a member of the Armed Forces, We may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

Workers' Compensation - We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks - We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if We believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

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. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes - If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if permitted or required by law.

Law Enforcement - We may release medical information if requested by a law-enforcement official acting pursuant to valid legal authority.

Coroners, Medical Examiners and Funeral Directors - We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a
deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities - We may release medical information about you to authorized federal officials for intelligence, counterintelligence, protection of the President, other authorized persons or foreign heads of state, for purpose of determining your own security clearance and other national security activities authorized by law.

Inmates - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Victims of Abuse - We may use your medical information in connection with reports of abuse, domestic violence, and other purposes as necessary of helpful to protect your health and safety and the health and safety of others.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding 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. Usually, this includes medical and billing records, but does not include private psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer at the address set forth on the first page of this notice. If you request a copy of the information, We may charge a fee as permitted by state law for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request Amendment - If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend or correct the information. You have the right to request an amendment for as long as the information is kept by or for the Practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer at the address set forth on the first page of this notice. In addition, you must provide a reason that supports your 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 or for the office;
- Is not part of the information which you would be permitted to inspect and copy; or,
- Is accurate and complete without the amendment.

Right to an Accounting of Disclosures - You have the right to request an "accounting of disclosures." This is a list of the disclosures We made of medical information about you, except for any disclosures concerning treatment payment or healthcare operations or disclosures we made pursuant to a written authorization from you.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer whose address is on the first page on this notice. Your request must state a time-period that 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, electronically). The first list you request within a 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 choose 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 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 surgery that you had.

***We are not required to agree to your request*.** If We do agree to the restriction, 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 our Privacy Officer at the address listed on the first page of this notice. In your request, 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 the limits 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 by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer at the address on the first page of this notice. We will not ask you the reason or your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice - You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, contact our Privacy Officer at the phone number and address set forth on page one of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information We already have about you as well as any information We receive in the future. We will post a copy of the current notice in the office and provide you with a copy of the current Notice upon request. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Practice's Privacy Officer at the address and/or telephone number set forth at the beginning of this notice. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

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Acknowledgement of Receipt of Notice of Privacy Practices

Robert Spira, MD
Joseph DePasquale, MD
Etan Spira, MD
Youssef Botros, MD

I acknowledge receipt as of the date set forth below of a copy of the Practice's **"Notice of Privacy Practices."**

_____ _____

Printed Name of Patient **Patient Date of Birth**

_____ _____

Signature of Patient (or Patient's Personal Representative) **Date**

If Personal Representative signs:

_____ _____

Printed name of Patient's Personal Representative **Date**

_____

Relationship of Personal Representative to Patient s Authority to Act for the Patient, if applicable

FormU

ESSEX-HUDSON
GASTROENTEROLOGY
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5 Franklin Avenue, Suite 109
Belleville, NJ, 07109
Phone 973-759-7240 Fax 973-759-72437243

Notice of Disclosure of Health Information to Family and Friends Involved in Your Care and Your Right to Object

Communications with Family Members/ Caregivers

In an effort to promote effective communication between the Practice, its patients and family and friends involved in a patient's care or payment of care and in recognition of the important role that family members, friends and others play in a patient's care or payment of care, it is the policy of the Practice to communicate to family members, friends or any other person(s) you may identify, information about you that is directly related to that family member's, friend's or caregiver's involvement in, your ·care or payment of care. Unless you object and direct us otherwise by checking the box below; we will communicate with your family or friends that information about you that is related to their involvement in your care or payment for care.

☐ I DO NOT want the Practice communicating any information to my family or friends. By checking that I understand that I am limiting the Practice's ability to communicate information about me to my spouse, children, significant other or other person(s) who may accompany me to a procedure or call or seek to act on my behalf or who otherwise may be involved in my care or the payment of my care.

By signing below, I acknowledge receiving and reading this Notice.

_____ _____

Print Name Signature

Date_____

FormD

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CONSENT USE AND DISCLOSURE FORM
(For Treatment, Payment and Health Operations)

I_____ understand that in the course of providing care to me the *{print name)*

Practice will receive, create, maintain and disclose information about me for the purpose of the Practice's and other health provider's provision of treatment, securing payment from me, an insurer, other third-party payer or responsible party, and/or in connection with the health care operations of the Practice and/or the operations other health providers who have treated me and as otherwise required or permitted by State and/or Federal Law. I understand that a further description of these anticipated uses and disclosures of my health information appears in the Practice's Notice of Privacy Practices.

I agree to the sharing, utilization, examination, and disclosure of any of my health information, including but not limited to known or suspected *HIV/*AIDS infection, mental healthrecords, communicable diseases, substance abuse and/or treatment, if applicable, as i s reasonably necessary by the Practice, its employees and other members of its workforce for the limited purpose of rendering treatment, securing payment for treatment rendered and conducting the Practice's operations. I further agree to the disclosure by the Practice of such information, as is reasonably necessary, to other health providers involved in my treatment and their employees and other members of their workforce for treatment, payment and health operations, to any private or governmental insurer, including Medicaid and Medicare and its intermediaries and agents, other third party payers, or other financially responsible party for the purpose of determining benefits and securing payment, and as otherwise permitted by State and/or Federal law.

This consent may be revoked at any time but, only to the extent that the Practice has not acted in reliance on it. If not previously revoked, this consent will remain valid as long as I am a patient of the Practice and for such period of time thereafter as is reasonably necessary to serve the purpose for which it was given; namely, the provision of treatment, securing payment for services rendered and conducting health operations.

_____ _____

Date

Signature of patient or legal representative
(If signed by a representative, print title
(e.g., parent/guardian, power of attorney)