

Gut Whisperer, PC

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICE**

You May Refuse to Sign This Acknowledgement

**I, _____, have received a copy of this office's Notice of
Privacy Practices.**

Please Print Name

Signature

Date

For Office Use Only

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:**

- () Individual refused to sign**
- () Communications barriers prohibited obtaining the acknowledgement**
- () An emergency situation prevented us from obtaining acknowledgement**
- () Other (Please Specify)**

Personal Representative 1 *(Please Print Clearly)*

Full Name: _____ Phone # _____

Relationship to You: _____ (such as: spouse, parent, child, friend)

Restrictions: _____

Personal Representative 2 *(Please Print Clearly)*

Full Name: _____ Phone _____

Relationship to You: _____ (such as: spouse, parent, child, friend)

Restrictions; _____

This authorization to release information to my Personal Representative will automatically expire in three (3) years after the date of my last visit to Gut Whisperer, PC.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish any person named above to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Officer at the address shown below. I understand that my revocation of this authorization will not affect any action that has been taken or information that has already been released, based upon this authorization, before receiving my request to revoke authorization.

Privacy Officer

Attn: Barbara
1543 W. 12600 S. Ste 102
Riverton, UT 84065
Phone # (801)563-5121 Fax # (801)566-3926

I, _____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization the Gut Whisperer, PC may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Signature: _____

Date: _____ *Complete and sign this form. You are entitled to a copy of this completed form.*

Gut Whisperer, PC

APPOINTMENT OF PERSONAL REPRESENTATIVE

Patient Name _____ Date of Birth _____

Purpose

This form allows you (the "Patient") to give Gut Whisperer, PC permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care; diagnoses; procedures; and personal information such as your date of birth and mailing address.

Each adult family member, including each adult child (age 18 or older) who wishes to name a Personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, do not complete this form. You are not required to name a Personal Representative, but if you do not, we will not release your protected health information to someone who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as a spouse, parent, child, friend, congressperson or union representative. You must provide the information requested below for each person before we can treat that person as your Personal Representative. If you need additional forms, you may copy this form or call us.

Please note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions.

Authorized Use and/or Disclosure

I understand that Gut Whisperer, PC's privacy practice is to not disclose my personal health information except for the purpose of treatment, payment and health care operations, or as required by law, without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named below for the purpose of assisting with or facilitating my health care and payment of any health benefits. Unless I have stated otherwise in Restrictions, I also allow my Personal Representative the following rights: the right to request amendment of my PHI; the right to request an accounting of disclosures of my PHI; and the right to request restrictions on disclosure of my PHI. I understand that if my Personal Representative is not a health plan, a health care provider, or another entity subject to federal or applicable state privacy laws, those laws may no longer protect my personal health information, and my Personal Representative may further disclose my protected health information without my authorization. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease; or I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described in Restrictions in this section.

EXPLANATION OF BINDING ARBITRATION

The patient received a verbal and written explanation of the following:

A binding arbitration agreement requires patients to submit all future claims to arbitration instead of having the claim heard in court by a judge or jury.

An arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. You select one arbitrator, your doctor selects one and you and the doctor agree on a third arbitrator selected from a list of persons trained and approved as arbitrators for the State and Federal courts in Utah.

You pay for the fees and expenses of your arbitrator, your doctor pays for his arbitrator. The fees and expenses of the third arbitrator are shared equally.

You have the right to rescind the agreement within thirty (30) days of signing the agreement.

The arbitration agreement is renewed each year unless it has been cancelled by letter sent by certified mail before the renewal date.

You have the right to have all of your questions about arbitration answered.

Patient Name _____

Responsible Party: _____ Date: _____

Office Staff Member: _____ Date: _____

Comments:

Gut Whisperer, P.C.
Dr. Uma Karnam M.D.
Dr. Kent J. Smith M.D.

I _____ DOB: _____

understand that it is my responsibility to verify with my insurance any labs/radiology or procedures that may be performed are done at a facility that is contracted with my insurance plan. Gut Whisperer, PC will not be responsible for any balance that I may owe if I do not verify this information.

Signature

Date

Gut Whisperer, PC

Date: _____

Patient's Name: _____ Sex: M F SSN: _____

Date of Birth: _____ Age: _____ Marital Status: M S D W

Address: _____ City: _____ Zip Code: _____

Home Telephone: _____ Employer Telephone: _____

Employer: _____ Employer Address: _____

Spouse's Name: _____ Spouse's Work Telephone: _____

Referring Physician: _____ Office #: _____

Emergency Contact (full name): _____ Telephone: _____

Primary Insurance: _____ Name of Insured: _____

Policy ID#: _____ Group #: _____

Insured's relationship to patient: _____ Insured's D.O.B: _____

Insured's Social Security Number: _____

Secondary Insurance: _____ Name of Insured: _____

Policy ID#: _____ Group #: _____

Insured's relationship to patient: _____ Insured's D.O.B: _____

Insured's Social Security Number: _____

****PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING****

If you are scheduled for a procedure at a hospital or surgical center, you will receive **TWO BILLS**; one from your physician and one from the facility where your procedure is performed.

1. I agree that I am responsible for this debt regardless of my insurance coverage and I agree to pay any unpaid balance in full.
2. In the event that I do not cancel my appointment within 24 hours I will be charged a \$25.00 NO SHOW FEE.
3. In the event that my account is not paid as agreed and becomes delinquent, I agree to pay a collection agency.
4. In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney fees and court costs.
5. If any portion of the providers services are disputed, I agree to submit myself to arbitration and will pay the cost of doing so.
6. I authorize the release of any medical or other information necessary to process this claim.
7. I authorize payment of medical benefits to the undersigned physician or supplier for the services described on any claim form.

SIGNATURE: _____ WITNESS: _____

Gut Whisperer, PC

Financial Agreement

Thank you for choosing us as your health care provider. We ask that you please understand that payment of your bill is necessary in order to keep health care accessible. The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

If we are participating provider with your insurance plan, we will take assignment of insurance benefits from that plan. All copayments and deductibles are due prior to treatment. A billing fee of \$25.00 will be assessed to all copayments that are not paid at the time services are rendered. Copayments that cannot be anticipated at the time of service will be billed once without penalty to the patient upon receipt of the insurance payment. There will be a \$25.00 No Show Fee if appointments are not cancelled within 24 hours of the appointment. By signing below you agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. In the event that payment in full, for charges incurred, is not made the undersigned agrees to pay all costs of collection including a 40% collection fee, attorney fees, court costs and interest at the rate of 1.5% per month (18% per year). If your bill requires being sent by certified mail, priority mail, or text message you will be responsible for a \$10.00 service charge, after a bill has been sent two times it will then be sent in one of these forms.

In the event that we are not participating with your insurance plan, payment is expected at the time of service. We will be happy to provide you all the necessary information for you to submit your claim to your insurance carrier to pursue reimbursement. Your insurance policy contract is between you and your carrier. Be sure that you understand your insurance policy coverage.

It is your responsibility to inform our office in a timely manner of any change in insurance coverage. We do not take the responsibility for claims denied for termination or change in coverage. Often these denials come to us after the allowed submission period for the new insurance has passed. Under these circumstances, the patient will be held responsible for payment in full for services rendered regardless of our status with that carrier as a provider. We do not bill third insurances or automobile insurances, but will be happy to provide you with forms that you can submit for the charges. Payment will be expected at the time that service is rendered for auto accident claims not covered under the primary and secondary medical plans.

If complete payment cannot be made at the time services are rendered, definite arrangements for payment must be made at that time. We cannot extend a line of credit through our office; however, we will try to be as helpful as possible in determining the most convenient payment options for you. It is our goal to provide health care through our practice that is accessible and affordable.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Gut Whisperer, PC or anyone acting on its behalf. I understand and agree that such calls may be initiated by Gut Whisperer, PC or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contract may include using pre-recorded/artificial voice message and/or the use of an automated dialing device and/or the use of text messages-some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me to anyone associated with me or acting on my behalf.

I have read, understand and agree to the provisions of the Financial Agreement. I further understand that Gut Whisperer reserves the right to alter this agreement at any time.

Signature of Patient or Guarantor of Patient

Date

Witness

Date

Family Medical History							
☐ No Knowledge of family history	Mother	Father	Sister	Brother	Child	Other	Who
Celiac Disease	☐	☐	☐	☐	☐	☐	
Colon Cancer	☐	☐	☐	☐	☐	☐	
Colon Polyps	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Gallbladder Disease	☐	☐	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	☐	☐	
Inflammatory Bowel Disease (Ulcerative colitis/Crohns)	☐	☐	☐	☐	☐	☐	
Liver Disease	☐	☐	☐	☐	☐	☐	
Other Cancers	☐	☐	☐	☐	☐	☐	
List Type of Cancer							
Diagnosis Not Listed Above	☐	☐	☐	☐	☐	☐	
List Diagnosis							
REVIEW OF SYSTEMS (check all symptoms that apply)							
Constitutional	ENT			Endocrine			
☐ Fever	☐ Changes in voice/hoarseness			☐ Diabetes			
☐ Fatigue	☐ Frequent throat clearing			☐ Thyroid problems			
☐ Weight loss	☐ Oral lesions			☐ Heat/cold intolerance			
☐ Weight gain	☐ Sensation of lump in throat			☐ Difficulty sleeping			
☐ Night sweats	☐ Food sticking in throat			Musculoskeletal			
Gastrointestinal	Cardiovascular			☐ Joint pains			
☐ Abdominal Pain	☐ Lower Extreimity swelling			☐ Joint swelling			
☐ Abdominal swelling/Bloating	☐ Irregular heart beat			Mental Health			
☐ Acid Reflux	☐ Chest pain			☐ Anxious/excessive worrying			
☐ Heart burn	Respiratory			☐ Feeling depressed			
☐ Difficulty swallowing	☐ Cough			☐ Confusion			
☐ Nausea	☐ Coughing up blood			☐ Alcohol abuse			
☐ Vomiting	☐ Shortness of breath			☐ Illicit substance abuse			
☐ Vomiting blood	Urinary			Neurological			
☐ Bloody or black tarry stools	☐ Blood in Urine			☐ Headache			
☐ Constipation	☐ Pain w/ Urination			☐ Tremors			
☐ Diarrhea	☐ Urine Incontinence			☐ Numbness			
☐ Stool Incontinence	(uncontrollable accidents/leaking)			Integumentary/Skin			
(uncontrollable accidents/leaking)	☐ Pelvic pain			☐ Rash			
☐ Rectal pain	Hematological			☐ Itching			
☐ Rectal itching	☐ Anemia			☐ Paleness			
	(low red blood cell count)			☐ Yellowing of skin			
	☐ Easy bruising/bleeding			Immunologic			
				☐ Immunosuppressed			
				☐ Seasonal allergies			
					PATIENT ROOMED AND CHART UPDATED BY		

NEW/RE-ESTABLISHING PATIENT FORM

DATE ____/____/____

Name _____ Age _____ Date of Birth ____/____/____

Address _____

Phone Number _____ Email Address _____

Primary Care Doctor _____ Pharmacy _____

ALLERGIES☐ NO KNOWN ALLERGIES☐ FOODS?(list below)☐ MEDICATIONS?(list below)**MEDICATIONS/STRENGTH (list all prescribed, over the counter medications, and vitamins you take)****Personal Medical History**

(check all that you have been diagnosed with)

☐ Anemia☐ Anxiety☐ Ascites (extra fluid in abdomen)☐ Asthma☐ Autoimmune disease☐ Barrett's Esophagus☐ Bipolar☐ Bleeding Disorder or Blood Clots☐ Cancer: What

type _____

☐ Congestive Heart Failure☐ COPD (emphysema)☐ Coronary Artery Disease☐ Crohns Disease☐ Depression☐ Diabetes☐ Diverticulosis/Diverticulitis☐ Endometriosis☐ Fatty Liver☐ Gallstones☐ GERD/ Acid Reflux☐ Heart Arrhythmia (A. Fib, SVT)☐ Heart attack (MI)☐ Heart stents☐ Helicobacter Pylori Gastritis☐ Hepatitis☐ High Blood Pressure (HTN)☐ Irritable Bowel Syndrome☐ Kidney Failure☐ Liver Disease or Cirrhosis☐ Migraine Headaches☐ Multiple Sclerosis☐ Osteoporosis☐ Ovarian Cysts☐ Pancreatitis☐ Peripheral Vascular Disease☐ Rheumatoid arthritis☐ Seizures☐ Scleroderma☐ Sleep Apnea☐ Stoke/TIA☐ Thyroid Disease/Problem☐ Ulcerative Colitis**Other Diagnosis Not Listed Above****PREVIOUS COLONOSCOPY**☐ No ☐ Yes

WHEN? _____

WHERE? _____

FINDINGS? _____

PREVIOUS EGD☐ No ☐ Yes

WHEN? _____

WHERE? _____

FINDINGS? _____

PREVIOUS SURGERIES/ DATES**SOCIAL HISTORY****Marital status**☐ Single ☐ Married ☐ Separated☐ Divorced ☐ Widowed**Children**☐ No ☐ Yes

How Many _____

Occupation**Employer****Use of Tobacco/Vape**☐ No ☐ Yes ☐ Quit

Type _____

How much daily _____

Do you drink alcohol☐ No ☐ Yes

How many per week _____

Do you use illicit drugs☐ No ☐ Yes

Type _____