CENTER FOR DIGESTIVE HEALTH

Phone: (248) 844-9710
Fax: (586) 726-8527
Website: www.troygastro.com

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Ronald Fogel, MDCM, MHSA

Dear Patient,

Welcome to our practice. We look forward to providing you with quality care.

As a courtesy to you (our patient), we will gather health records (labs, radiology, endoscopy, pathology, etc.) pertinent to your visit from these health systems – Beaumont, Henry Ford and U of M (if available). These systems will be accessed with the last 4 digits of your social security number. If you elect not to provide the last four digits of your social security number, please request those medical records be faxed to our office at the # below prior to your visit. We will also request your records from your Primary Care Physician or Referring Provider.

If you have any other health records pertinent to your gastroenterology visit, we do not have access to those records. It is **your responsibility** to contact that Provider or Facility to request the records. The records may be faxed to our Medical Records department at **(586) 726-8527**. You may utilize the attached Covered Entity to Covered Entity Authorization Form or you can contact the Provider or Facility where you need to obtain records for their Medical Records Release form.

*For the most complete initial visit, it is important these records be provided to us prior to your visit. The process to get outside medical records can take several days depending on the timely response of all parties involved.

Sincerely,

The Physicians and Staff at Center for Digestive Health

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Authorization of Disclosure of Protected Health Information by Another Covered Entity for Use by Center for Digestive Health

Information to be obtained under this authorization includes:

Medical records: ***Any*** procedure reports & pathology reports. Also include: office notes, labs, and discharge summary (if patient was hospitalized) ***within the last year***.

Purposes of Disclosure
Information listed above will be disclosed for the following purposes: Continuity of Care and Medical History

Persons Authorized to Disclose Information to our Physicians:
Name of Physician/Practice:_____
Address:_____ Phone: _____
_____ Fax: _____

_____

Persons Authorized to Receive Disclosed Information:

Center for Digestive Health
1701 E South Blvd., Suite 300
Rochester Hills, MI 48307
(248) 844-9710 phone
(586) 726-8527 fax

Expiration Date of Authorization
This authorization is effective through **1 Year** unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Center for Digestive Health. You should contact the practice manager to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed. The privacy of this information should be protected under the federal privacy regulations at the receiving entity.

Rights of the Individual
- You may inspect or request a copy of information that is used or disclosed under this authorization.
- You may refuse to sign this authorization.

_____ _____
Name of Patient (Print or Type) Date of Birth

_____ _____
Signature of Patient (or Patient Representative) Date Signed

Troy Gastroenterology, P.C.

Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

GENERAL PATIENT INFORMATION

Please complete the following form and bring it with you on the day of your scheduled appointment.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: ☐ Home ☐ Cell ☐ Work ☐ Other: (____) _____ Can we leave voicemail? ☐ YES ☐ NO

Alternate Phone #: ☐ Home ☐ Cell ☐ Work ☐ Other: (____) _____ Can we leave voicemail? ☐ YES ☐ NO

Email: _____ Last 4 Digits of Social Security #: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced

Race: ☐ Caucasian ☐ African American ☐ American Indian/Alaska Native
☐ Chinese/Japanese/Korean ☐ Filipino ☐ Multiracial
☐ Pacific Islander ☐ Other _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other _____

Language: ☐ English ☐ Arabic ☐ Japanese/Chinese/Vietnamese
☐ Korean ☐ Polish ☐ Spanish
☐ Hindi ☐ German ☐ French
☐ Greek ☐ Mandarin ☐ Romanian
☐ Other _____

PATIENT EMPLOYMENT

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Other

Employer: _____ Phone#: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber Name: _____

Relationship to Patient: _____ Date of Birth: _____

Secondary Insurance: _____ Subscriber Name: _____

Relationship to Patient: _____ Date of Birth: _____

MEDICAL INFORMATION-PATIENT HISTORY

MEDICATIONS: Please list all current prescriptions and over the counter medications.
☐ Check box if you have multiple medications and attach list.

MEDICATION NAME DOSE FREQUENCY

_____
_____
_____

ALLERGIES: ☐ Check box if you have multiple medication allergies and attach list.

Drug Allergies

_____ _____
_____ _____
_____ _____

Check if allergic to:
☐ **dairy** ☐ **iodine/shellfish/ IVP dye**
☐ **seasonal/ environmental**
☐ **other** _____

MEDICAL HISTORY: Please check to indicate if you have any history of the following disorders.

☐ Emphysema
☐ Pneumonia/ Bronchitis
☐ Arthritis
☐ Depression
☐ Anemia
☐ Blood Transfusion
☐ Blood Disorder
☐ Liver Disease
☐ Hepatitis/ HIV
☐ Ulcer
☐ Crohns
☐ Pancreatitis
☐ IBS
☐ Ulcerative Colitis
☐ Weight Loss
☐ High Cholesterol
☐ High Blood Pressure
☐ Irregular Pulse
☐ Pacemaker/Defibrillator
☐ Congestive Heart Failure
☐ Heart Murmur
☐ Chest Pain
☐ Heart Problems: _____
☐ Kidney Failure/Dialysis
☐ Seizure
☐ Stroke
☐ Glaucoma
☐ Thyroid
☐ Diabetes
☐ Hypoglycemia
☐ Cancer:_____
☐ Colon Polyps
☐ Learning Disabilities
☐ Physical Limitations

Please list any other major illness: _____

SURGICAL HISTORY: Please check to indicate if you have any history of the following operations:

☐ Colostomy ☐ Ileostomy ☐ Gastric Bypass/ Banding ☐ Joint replacement ☐ Metal implant ☐ IV Port
☐ Filters ☐ Stents (biliary cardiac, colon) ☐ Pacemaker ☐ Defibrillator

Please list all major operations: _____

Have you ever had? ☐Colonoscopy ☐EGD ☐ Upper GI ☐ Barium Enema ☐ Ultrasound ☐ Abdominal CT/ MRI

If yes, where? List Facility/Physician/Hospital: _____

SOCIAL: Please indicate your consumption of the following as they are important to GI disorders.

	DO YOU CONSUME?	HOW OFTEN?	AMOUNT
Alcohol	☐ Yes ☐ No		
Nicotine	☐ Yes ☐ No		
Caffeine	☐ Yes ☐ No		
Recreational Drugs (Marijuana, cocaine,etc.)	☐ Yes ☐ No		
	DO YOU EXPERIENCE?		
Domestic Violence	☐ Yes ☐ No		

FAMILY HISTORY: Please complete the following information for your blood relatives:

	Father	Mother	Brother(s)	Sister(s)	Other:
Deceased	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer History:					
Colon	☐	☐	☐	☐	☐
Esophageal	☐	☐	☐	☐	☐
Pancreatic	☐	☐	☐	☐	☐
Uterine/Breast	☐	☐	☐	☐	☐
Other (specify)	☐_____	☐_____	☐_____	☐_____	☐
Digestive History:					
Crohns	☐	☐	☐	☐	☐
Reflux	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐
Other (Specify)	☐_____	☐_____	☐_____	☐ _____	☐
Cardiac History:	☐_____	☐_____	☐_____	☐ _____	☐

MEDICAL INFORMATION-PATIENT HISTORY

Reason for visit:_____

Describe your symptoms:_____

Please indicate yes or no if you have any of the symptoms listed below. Do you now, or do you have a history of:

GASTROINTESTINAL

Poor appetite	☐Yes	☐No
Difficulty in swallowing	☐Yes	☐No
Heartburn	☐Yes	☐No
Nausea or vomiting	☐Yes	☐No
Bloating	☐Yes	☐No
Belching	☐Yes	☐No
Regurgitation	☐Yes	☐No
Constipation	☐Yes	☐No
Diarrhea	☐Yes	☐No
Abdominal pain	☐Yes	☐No
Changes in bowel habits	☐Yes	☐No
Rectal bleeding	☐Yes	☐No
Jaundice	☐Yes	☐No
Ulcer	☐Yes	☐No
Black, tarry stools	☐Yes	☐No

CONSTITUTIONAL

Recent weight change	☐Yes	☐No
Fever	☐Yes	☐No
Fatigue	☐Yes	☐No
Night Sweats	☐Yes	☐No
Infections/Injuries	☐Yes	☐No

EYES

Blurred vision	☐Yes	☐No
Infections/Injuries	☐Yes	☐No
Double/blurred vision	☐Yes	☐No

EARS/NOSE/MOUTH

Hearing loss	☐Yes	☐No
Ringing in ears	☐Yes	☐No
Mouth sores	☐Yes	☐No
Sore throat	☐Yes	☐No

CARDIOVASCULAR

Shortness of breath	☐Yes	☐No
Swelling of ankles/feet	☐Yes	☐No
Heart murmur	☐Yes	☐No
Irregular pulse	☐Yes	☐No

RESPIRATORY

Chronic cough	☐Yes	☐No
Spitting up blood	☐Yes	☐No
Wheezing	☐Yes	☐No

SKIN

Rash	☐Yes	☐No
Itching	☐Yes	☐No

GENITOURINARY

Burning with urination	☐Yes	☐No
Blood in urine	☐Yes	☐No
Frequent/urgent urination	☐Yes	☐No
Incontinence	☐Yes	☐No

NEUROLOGICAL

Headaches	☐Yes	☐No
Numbness	☐Yes	☐No
Disorientation	☐Yes	☐No
Weakness	☐Yes	☐No

ENDOCRINE

Heat or cold intolerance	☐Yes	☐No
Excessive thirst / urination	☐Yes	☐No

HEMATOLOGICAL

Bleeding/ /bruising	☐Yes	☐No
Swollen glands	☐Yes	☐No

MUSCULOSKELETAL

Joint/muscle pain	☐Yes	☐No
Muscle pain	☐Yes	☐No
Arm/leg weakness/ numbness	☐Yes	☐No
Back/neck pain	☐Yes	☐No

PSYCHIATRIC

Memory loss or confusion	☐Yes	☐No

To expedite prescription prior authorizations indicate if you have ever taken any of the following medications:

Medication	Yes	Dates (if known)	Medication	Yes	Dates (if known)	Medication	Yes	Dates (if known)
Aciphex			**Fibersure**			**Pepcid**		
Amitiza			**Glycolax**			**Prevacid**		
Benefiber			**Kapidex**			**Prilosec**		
Citrucel			**Kristalose**			**Protonix**		
Correctol			**Lactulose**			**Rabeprazole**		
Dexilant			**Lansoprazole**			**Ranitidine**		
Dexlansoprazole			**Lubiprostone**			**Reglan**		
Dulcolax			**Metamucil**			**Tagamet**		
Dulcolax Balance			**Metoclopramide**			**Trulance**		
Esomeprazole			**Miralax**			**Zantac**		
Ex-Lax			**Nexium**			**Zelnorm**		
Famotidine			**Omeprazole**			**Zegerid**		
Fibercon			**Pantoprazole**			**Other**		

Patient Signature:_____ Date:_____

Troy Gastroenterology, P.C.

And its Affiliated Covered Entities: Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Troy Gastroenterology and its affiliated covered entities listed above. Our Notice of Privacy Practices provides you with information about how we can use and disclose your protected health information as permitted under federal and state law. We encourage you to read it in full.

Troy Gastroenterology reserves the right to change the privacy practices outlined in the notice.

Name of Patient (or Patient Representative)	Date
Signature of Patient (or Patient Representative)	Relationship of Patient Representative to Patient

In the future, our Notice of Privacy Practices will be provided to you upon your request.

For Office Use Only at First Encounter:

I attempted to obtain a written *Acknowledgement of Receipt of Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Emergency situation prevented signature
- ☐ Other (please specify)

Employee Name	Date

Troy Gastroenterology, P.C.

And its Affiliated Covered Entities: Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

HIPAA Authorization for Disclosure of Protected Health Information

At times we may need to contact you about test results, appointments, referrals or billing/insurance information. In an effort to better serve you, protect your privacy and follow federal guidelines, please consider the following:

List family members and/or other persons, if any, whom we may inform about your general medical condition and your diagnosis, including treatment, payment and health care operations. Do not list your physician in this section. *We will only provide the minimum amount of information necessary.*

Name _____ Phone Number _____ Leave Voicemail YES NO

Address _____ Relationship to Patient: _____

Name _____ Phone Number _____ Leave Voicemail: YES NO

Address _____ Relationship to Patient: _____

Name _____ Phone Number _____ Leave Voicemail: YES NO

Address _____ Relationship to Patient: _____

If you do not want our office to discuss any portion of your medical care or financial information with anyone but you, please initial on this line_____ (Release to Self Only).

Expiration Date of Authorization:
This authorization is effective for ***one year*** unless revoked or terminated earlier by the patient or the patient's representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written letter to Troy Gastroenterology. You should contact the HIPAA Officer at 1701 E. South Blvd, Suite 300, Rochester Hills, Michigan 48307 to terminate this authorization.

Treatment, Payment or Operations
Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is provided by the Privacy Rule.

Potential for Redisclosure
Any disclosure information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Rights of the Individual
- You may inspect or request a copy of information that is used or disclosed under this authorization.
- You may refuse to sign this authorization.

Effect of Refusing Authorization
If you refuse to sign this authorization, Troy Gastroenterology will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Please note: While we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient/Patient Representative Date Signed

_____
Relationship of Patient Representative to Patient

Troy Gastroenterology, P.C.

And its Affiliated Covered Entities: Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

OFFICE AND FINANCIAL POLICY

OFFICE HOURS:

Regular office hours are 8:30 a.m. to 4:30 p.m. Monday through Friday. Office visits are by appointment only. We strongly believe in the value of your time and will do our best to keep your scheduled appointment running smoothly. However, emergencies do occur and may cause a delay.

TELEPHONE CALLS:

All offices share the number (248) 844-9710. Please listen to all prompts and our phone system will direct you to the area of your choice. Our physicians utilize designated medical staff to return patient calls with their recommendations. If you have a question for your physician, listen through all the prompts and you will be automatically directed to the medical staff. Non-urgent calls will be returned within 48 hours. Prescription refill requests will be processed within 72 hours. The telephone system is shut down at 4:30 p.m. to facilitate return calls to patients.

FEES AND PAYMENTS:

Our practice is committed to providing you with the best possible treatment and we charge what is customary in our area. Full payment of patient responsibilities, including copay, is expected at the time of service by cash, check, Visa, MasterCard, or Discover. A $5 service fee will be charged for any office visit copay that is not paid at the time of service.

RESCHEDULE/CANCELLATION/MISSED APPOINTMENT FEES

For Endo Procedures, patients will have 3 business days from the point of scheduling to cancel/reschedule a procedure without penalty. Patients that reschedule outside of the 3 day window, will incur a $50 fee. Patients that cancel outside the 3 day window will incur a $100 fee.

For office, telemedicine, or infusion appointments, if a patient cancels with less than 24 hour notice, a $25 fee will be assessed.

All Missed Appointments will incur a $50-$100 fee based on the service that was missed/no show.

Reschedule, cancellation and missed appointment fees must be paid prior to scheduling future appointments.

***MINOR PATIENTS*:**

Several of our physicians will begin treating patients at the age of 16. The parent, guardian, or other adult accompanying a minor is responsible for payment. A parent or guardian must sign the required office forms prior to scheduling an appointment. An unaccompanied minor must also provide a permission note authorizing service and a telephone number where a parent/guardian may be reached.

E-PRESCRIBING:

Our office utilizes e-Prescribing to send your prescriptions to the pharmacy of your choice. E-Prescribing greatly reduces medication errors and enhances patient safety. We utilize this program for these reasons:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.
- **Controlled Substances** – As of October 1, 2021, we will only be able to e-prescribe controlled substances to the pharmacy of your choice. Please be advised: controlled substances are not able to be transferred.

POLICY ON NON-DISCRIMINATION AND SECTION 1557 OF THE AFFORDABLE CARE ACT:

Troy Gastroenterology, P.C. complies with applicable federal civil rights laws and does not discriminate against any individual on the basis of age, race, color, ethnicity or national origin, religion, creed, language, disability, socioeconomic status, sex, sexual orientation, gender identity or expression, and/or veteran status in admission, treatment, participation, or receipt of the services and benefits under any of its health programs and activities, and in staff and employee assignments to patients, whether carried out by the Practice directly or through a contractor or any other entity with which the Practice arranges to carry out its programs and activities.

The Practice will provide appropriate auxiliary aids and services to individuals with disabilities and language assistance services to individuals with limited English proficiency when needed to ensure equal opportunity and meaningful access to the Practice's health programs, services, and activities. Examples of aids and services include, but are not limited to, qualified sign language interpreters, written information in alternate formats, foreign language interpreters and information translated into other languages. The Practice will provide aids and services in a timely manner and free of charge.

Troy Gastroenterology, P.C.

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OFFICE AND FINANCIAL POLICY

INFORMED CONSENT FOR TELEHEALTH CONSULTATIONS:

To better serve the needs of people in the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. This process is referred to as "telemedicine" or "telehealth." This means that you may be evaluated and treated by a health care provider or specialist from a distant location. Because this may be different than the type of consultation with which you are familiar, **it is important that you understand and agree to the following statements.**

1. The health care provider or specialist will be at a different location from me.
2. I will be informed if any additional personnel are to be present other than myself. I will give my verbal permission prior to the entry of the additional personnel.
3. I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based medical services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital in my immediate area.
4. I understand there is the potential for issues with the technology, including interruptions, unauthorized access and technical difficulties.
5. The health care provider will keep a record of the "telehealth visit" in my medical record.

INSURANCE BILLING:

Troy Gastroenterology participates with most insurance plans. We follow the rules and guidelines of the insurance plans. If you have insurance coverage, please understand that your policy is a contract between you and the insurance company, not the practice and the insurance company. We will file a claim with your insurance company for payment of services rendered. If the insurance company does not respond, or the claim is outstanding for more than 90 days, the responsibility of payment will be transferred to the patient. Patients should be aware of the following prior to their appointment:

- Verify that our physicians are contracted with your insurance plan.
- Familiarize yourself with the out of pocket expenses associated with your insurance plan. These can include co-pays, coinsurance and deductible requirements. You are responsible to pay these amounts according to your contract benefits.
- Not all services are benefits under all contracts. It is the patient's responsibility to know their coverage. Note that some screening procedures may not be covered. We suggest you contact your insurance company prior to your visit to get coverage details. A covered service remains subject to any applicable co-pay, coinsurance and deductible requirements.
- Many HMO insurance plans require a referral or authorization for service. The patient is responsible for obtaining any necessary office visit referrals per the rules of their insurance. If a necessary referral cannot be confirmed 24 hours prior to the appointment, you will be required to reschedule the appointment. Our billing department will assist you in obtaining necessary authorizations for procedures and diagnostic testing.

If you do not have insurance coverage, please contact our billing department to discuss payment options.

Please refer to our website for a complete description of our financial policy.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of medical health benefits to Troy Gastroenterology, P.C. and its Affiliated Covered Entities for services rendered under the supervision of a physician and/or licensed clinician. I authorize any holder of medical or other information about me to release to the health insurance company any information needed to determine these benefits for related services. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the demographic and insurance information given by me in applying for payment is correct.

I understand the office policies contained in this form. I have carefully read and fully understand the above statements and have had the opportunity to ask questions. I voluntarily consent to health care services provided by my health care provider, including both in-person and telehealth visits, which may include diagnostic tests, drugs, examinations, and medical or surgical treatments considered necessary to treat my health problem.

Patient Name (Print) _____ Signature _____ Date _____

Guardian Name (Print)_____ Signature _____ Date _____

Troy Gastroenterology, P.C.

And its Affiliated Covered Entities: Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

Notice of Privacy Practices
Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record (we may charge reasonable fees for a copy)
- Correct your paper or electronic medical record in certain situations
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information in certain situations
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic (if maintained electronically by us) or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Officer using the information on the last page of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: We may send your colonoscopy report to your Primary Care Physician.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research. Troy Gastroenterology, P.C. has a research department. Research is conducted under strict Federal Drug Administration (FDA) and Institutional Review Board (IRB) guidelines designed to protect the subjects of research. For example, our researches may look for patients with specific medical characteristics or treatment to prepare a research protocol. For actual research studies, we would contact you to obtain your authorization to be a part of study.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

For clarification, please note that we do not create or manage a hospital directory of patient names nor do we create or maintain psychotherapy notes. The HIPAA privacy regulations establish a minimum acceptable threshold for the use and disclosure of a patient's health information. State and other federal laws may require greater limits. The State of Michigan sets forth greater protections governing the use and disclosure of certain types of records, reports and data including substance abuse treatment HIV/AIDS, communicable diseases, and mental illness.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and make a copy of it available to you.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for This Notice

- **Effective Date of Notice: May 22, 2017**

- **This Notice of Privacy Practices also applies to our affiliated covered entities:**
  Center for Digestive Health
  Macomb Endoscopy Center
  Surgical Centers of Michigan

If you have questions, would like additional information, or you believe your privacy rights have been violated, you may contact our Privacy Official:
Phone: (248) 844-9710 Address: 1701 E. South Boulevard, Suite 300, Rochester Hills, MI 48307