

Borland-Groover Clinic
— Notice of Privacy Policy —

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Borland-Groover Clinic
Acknowledgement of Receipt of Privacy Policy

We are required by law to provide you with our Notice of Privacy Practices.
To ensure that our records are accurate, please sign this form and return it to our receptionist
to acknowledge that you have been provided with a copy of our notice.

I acknowledge receipt of Borland-Groover Clinic's Notice of Privacy Practices.

I hereby authorize Borland-Groover Clinic to share and/or discuss my medical information with the following individuals:

1. _____ 2. _____

Patient's Signature

Date

Patient's Name (please print)

Introduction

At Borland-Groover Clinic, we are committed to treating and using protected health information about you responsibly. This notice of health information practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Borland-Groover Clinic, a record of your visit is made. Typically, this record contains your symptoms, examination notes, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning our care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- Tool in educating health professionals,
- Source of data for medical research,
- Source of data for our planning and marketing, and
- Tool with which we can access and improve the care we tender and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Borland-Groover Clinic, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.524,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.538,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Borland-Groover Clinic is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Borland-Groover Clinic Financial Policy

It is the policy of Borland-Groover Clinic to provide our patients with access to the highest quality gastroenterological care available. In order for us to do so, we must ensure that we are able to meet our operational expenses. We ask that you read, understand, and sign our Financial Policy prior to receiving treatment.

PAYMENT AT TIME OF SERVICE

As a courtesy, we will bill your insurance for all services; however, we ask that you pay any portion of your costs not covered by your insurance due to deductibles, co-insurances or co-payments on the day of service. Billing for these items is not only costly, but our statements often go unpaid. This results in increased costs to both you and our other patients.

SUBMISSION OF CLAIMS

Your health insurance plan is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, charges not paid by your insurance company are your responsibility. Working together, we can resolve most insurance issues in a mutually acceptable manner; nevertheless, it is the patient's responsibility to understand his or her policy limitations. In the event your health insurance determines that they will not cover a service that you have received, you will be responsible for payment.

OUTSTANDING BALANCES

We urge you to keep your account current to avoid any misunderstandings with our office. When an account balance becomes more than 90 days past due, it will be referred to an outside collection agency. At that time, any additional fees incurred on the account will be the responsibility of the patient. If you need to make special payment arrangements, it is your responsibility to contact one of our financial counselors before your account is sent to an agency. Minimum monthly payment arrangements may be made for no less than \$50.00 unless approved by the Director of Finance. As a last resort, patients who fail to make payments could be terminated from the practice.

PAYMENT OPTIONS

You will receive monthly statements. The amount shown in the "PLEASE PAY THIS AMOUNT" box is your financial obligation. It is due and payable upon receipt. For your convenience, we accept payment in the form of cash or check and from Visa, MasterCard, American Express and Discover. Payments may be made on our website at www.borland-groover.com, called in at (904) 398-2183, or mailed to 4800 Belfort Road, Jacksonville, Florida 32256.

CHARITY CARE

Our financial counselors are available to assist our patients in applying to receive charity care. This may be available for those who earn up to 200% of Federal Poverty Guidelines.

Patient Name

Patient Signature

Date

By signing above, you agree to all the terms and conditions contained herein.

PATIENT GENERATED MEDICAL HISTORY REVIEW OF SYSTEMS

Please circle "Yes" or "No" to the questions below.

General

Are you constantly tired? Yes No Have you had a change in weight? Yes No

Gastrointestinal

Is your appetite poor? Yes No Do you have heartburn? Yes No

Do you feel bloated? Yes No Do you have a sour or bitter
taste in your mouth? Yes No

Do you belch a lot? Yes No Do you regurgitate your sour
stomach contents into your throat? Yes No

Are you often sick to
your stomach (nauseated)? Yes No

Do you suffer from frequent
indigestion? Yes No Do you vomit often? Yes No

Do you have severe pains in
your stomach? Yes No Have you ever vomited blood? Yes No

Do you suffer from frequent
loose bowel movements? Yes No Have you noticed a change
in stool thickness? Yes No

Have you ever had serious liver
or gallbladder trouble? Yes No Have you passed black stools? Yes No

Does food stick in your throat
or chest when swallowing? Yes No Do you have trouble with constipation? Yes No

Have you ever had bloody
diarrhea or have you passed
blood in your stool? Yes No Do you pass excessive gas? Yes No

Have you ever had
Hemorrhoids (piles)? Yes No Have you ever been told you have
irritable bowel or spastic colon? Yes No

Do you have difficulty swallowing? Yes No Do you ever soil yourself? Yes No

Have you gained or lost a great
deal of weight lately? Yes No

Have you ever had jaundice (yellow
eyes and skin)? Yes No

PATIENT GENERATED MEDICAL HISTORY REVIEW OF SYSTEMS

Neurological

Do you have frequent headaches? Yes No

Do you have dizzy or fainting spells? Yes No

Eyes

Has your vision failed? Yes No
Explain: _____

Has your eyesight often
blacked out? Yes No

Do your eyes constantly
blink or water? Yes No

Are your eyes often red
or inflamed? Yes No

Ears

Has your hearing gotten
worse lately? Yes No

Do you have constant
ringing in your ears? Yes No

Nose and Throat

Do you often feel a choking
lump in your throat? Yes No

Do you have constant
nasal congestion? Yes No

Do you have constant coughing? Yes No

Musculoskeletal

Do you have frequent back pain? Yes No

Do your joints swell? Yes No

Are muscles and joints stiff
and painful? Yes No

Do you have persistant leg pain/cramping? Yes No

Bleeding Tendencies

Have you ever had a tendency
to bleed easily? Yes No

Do you bruise easily? Yes No

Have you had frequent
nose bleeds? Yes No

Do your gums bleed? Yes No

Have you ever had anemia? Yes No

PATIENT GENERATED MEDICAL HISTORY REVIEW OF SYSTEMS

Cardio - Respiratory

<p>Have you ever had TB? Yes No</p> <p>Do you have pains in your heart or chest? Yes No</p> <p>Do you have difficulty breathing? Yes No</p> <p>Have you ever been told you have a heart murmur? Yes No</p> <p>Has your doctor ever said you have heart trouble? Yes No</p> <p>Have you ever coughed up blood? Yes No</p>		<p>Has your doctor ever said your blood pressure was too high? Yes No</p> <p>Do you have thumping or racing of the heart? Yes No</p> <p>Do you ever get out of breath with minimal activity? Yes No</p> <p>Do cold hands and feet ever trouble you even in hot weather? Yes No</p> <p>Do you suffer from asthma? Yes No</p>
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Genitourinary

<p>Has your doctor ever said you had a hernia? Yes No</p> <p>Do you ever have burning or pain while urinating? Yes No</p> <p>Has a doctor ever said you had kidney or bladder disease? Yes No</p>		<p>Have you ever passed blood while urinating? Yes No</p> <p>Do you ever lose control of your bladder? Yes No</p> <p>Has a doctor ever said you had kidney stones? Yes No</p>
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Menstrual History

(Women Only)

<p>Are you troubled with bleeding between periods? Yes No</p>		<p>Do you have excessive bleeding and passage of clots with periods? Yes No</p>
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When was your last period? _____

Number of pregnancies? _____

Number of miscarriages? _____

Skin

Do you have psoriasis? Yes No

Have you ever had skin rashes? Yes No

Have you ever had persistent itching? Yes No

Physician Signature

Date Reviewed
