Imad I. Nassif, M.D., A.G.A.F.
Board Certified Gastroenterology

9050 E. 29th St. N.
Suite 100
Wichita, Kansas 67226

(316) 219-9651
FAX: (316) 219-9655
Endoscopy Line: (888) 31-COLON
(312-6566)

Dear Patient:

Welcome to the office of Dr. Imad Nassif. Enclosed you will find paperwork for all new patients. Please complete the paperwork and bring it with you to your visit along with your insurance card (s). If your insurance requires a referral, it is the responsibility of the patient to obtain that referral.

Notice of Privacy Practice: this is the privacy policy of our office. This copy is yours to keep.

Acknowledgement of Receipt of Notice of Privacy Practice Form: this form verifies that you have received the Notice of Privacy Practice. Please print your name, date and then sign your name in the highlighted areas.

Assignment of Benefits: Please fill out the highlighted area. **Do not fill out the insurance area**. Please sign and date at the bottom.

Health History: Please fill this out as best as you can. You may bring a copy of your list of medications if they will not fit on this form.

If you would like to view your test results via a secure site, please complete the "My Care Plus" form.

Please arrive with your paperwork 5 to 10 minutes early for your appointment. If you have any questions, please contact our office.

EFFECTIVE JULY 15, 2012 THERE WILL BE A $50 CHARGE FOR ANY OFFICE APPOINTMENT MISSED, CANCELLED OR RESCHEDULED WITHOUT 24 HOUR NOTICE.

Thank You.

Appointment Date _____ Time _____

IMAD NASSIF, M.D.
NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer at 316-262-4467.

WHY WE ARE PROVIDING THIS NOTICE:

IMAD NASSIF, M.D. compiles information relating to you and the treatment and services you receive. This information is called protected health information (PHI) and is maintained in a designated record set. We may use and disclose this information in various ways. Sometimes your agreement or authorization is necessary for us to use or disclose your information and sometimes it is not. This Notice describes how we use and disclose your protected health information and your rights. We are required by law to give you this Notice, and we are required to follow it. We may change this Notice at any time if the law changes or when our policies change. If we change the Notice you will be given a revised Notice. You may also access this Notice at our website: www.cancercenterofkansas.com.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION THAT MAY BE MADE *WITHOUT YOUR AUTHORIZATION*:

1. For your treatment. We may share your protected health information with other treatment providers. For example, if you have a heart condition we may use your information to contact a specialist and may send your information to that specialist. We may send your information to other treatment providers, as necessary.

2. For payment. We may share your protected health information with anyone who may pay for your treatment. For example, we may need to obtain a pre-authorization for treatment or send your health information to an insurance company so it may pay for treatment. However, if you pay out of pocket for your treatment and make a specific request that we not send information to your insurance company for that treatment, we will not send that information to your insurer except under certain circumstances.

3. For our healthcare operations. We may use and disclose your protected health information when it is necessary for us to function as a business. For example, when we contract with other businesses to do specific tasks for us, we may share your protected health information related to those tasks. When we do this, the business agrees in the contract to protect your health information and use and disclose such health information only to the extent IMAD NASSIF, M.D. would be able to do so. These businesses are called Business Associates. Another example is if we want to see how well our staff is doing, we may use your protected health information to review their performance.

4. For appointment reminders. We may use your protected health information to remind you of appointments, including leaving a voicemail message.

5. For Surveys. We may use and disclose your protected health information to contact you to assess your satisfaction with our services.

6. For providing your information on treatment alternatives or other services. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may also use and disclose protected health information to tell you about health-related benefits or services that may be of interest to you. In some cases the facility may receive payment for these activities. We will give you the opportunity to let us know if you no longer wish to receive this type of information.

7. To discuss your treatment with other people who are involved with your care. We may disclose your health information to a friend or family member who is involved in your care. We may also disclose your health information to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

8. Research. Under certain circumstances, we may use and disclose your protected health information for medical research. All research projects, however, are subject to a special approval process. Before we use or disclose your health information for research, the project will have been approved.

9. As Required By Law. We will disclose your protected health information when the law requires us to do so.

10. To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

11. Organ and Tissue Donation. We may use or disclose your protected health information to an organ donation bank or to other organizations that handle organ procurement to assist with organ or tissue donation and transplantation.

12. Military and Veterans. The protected health information of members of the United States Armed Forces members of a foreign military authority may be disclosed as required by military command authorities.

13. Employers. We may disclose your protected health information to your employer if we provide you with health care services at your employer's request and the services are related to an evaluation for medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. We will tell you when we make this type of disclosure.

14. Workers' Compensation. We may release your protected health information for workers' compensation or similar programs providing you benefits for work-related injuries or illness.

15. Public Health Risks. We may disclose your protected health information for public health activities which include the prevention or control of 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 devices or products; 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; or to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. If you agree, we can provide immunization information to schools.

16. Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and civil rights laws.

17. Legal Proceedings. We may disclose your protected health information when we receive a court or administrative order. We may also disclose your protected health information if we get a subpoena, or another type of discovery request. If there is no court order or judicial subpoena, the attorneys must make an effort to tell you about the request for your protected health information.

18. Law Enforcement. When a law enforcement official requests your protected health information, it may be disclosed in response to a court order, subpoena, warrant, summons, or similar process. It may also be disclosed to help law enforcement identify or locate a suspect, fugitive, material witness, or missing person. We may also disclose protected health information about the victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct at IMAD NASSIF, M.D.; or in an emergency to report a crime, the location of the crime, victims of the crime, or to identify the person who committed the crime.

19. Coroners, Medical Examiners, and Funeral Directors. We may disclose your protected health information to a coroner, medical examiner, or a funeral director.

20. National Security and Intelligence Activities. When authorized by law, we may disclose your protected health information to federal officials for intelligence, counterintelligence, and other national security activities.

21. Protective Services for the President and Others. We may disclose your protected health information to certain federal officials so they may provide protection to the President, other persons, or foreign heads of state, or to conduct special investigations.

22. Inmates or Persons in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or a law enforcement official when it is necessary for the institution to provide you with health care; when it is necessary to protect your health and safety or the health and safety of others; or when it is necessary for the safety and security of the correctional institution.

23. Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

OTHER USES AND DISCLOSURES:

1. Most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and uses and disclosures that constitute a sale of protected health information require your authorization. Psychotherapy notes are a particular type of protected health information. Mental health records generally are not considered psychotherapy notes. Your authorization is necessary for us to disclose psychotherapy notes.

2. There are some circumstances when we directly or indirectly receive a financial (e.g., monetary payment) or non-financial (e.g., in-kind item or service) benefit from a use or disclosure of your protected health information. Your authorization is necessary for us to sell your protected health information. Your authorization is also necessary for some marketing uses of your protected health information.

3. Other uses and disclosures of your protected health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may revoke your authorization in writing at any time, provided you notify us. If you revoke your authorization, it will not take back any disclosures we have already made.

YOUR HEALTH INFORMATION RIGHTS:

1. Right to Access. You have the right to access, or to inspect and obtain a copy of your protected health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form so we have the information we need to process your request. You may request that your records be provided in an electronic format and we can work together to agree on an appropriate electronic format. Or you can receive your records in a paper copy. You may also direct that your protected health information be sent in electronic format to another individual. You may be charged a reasonable fee for access. We can refuse access under certain circumstances. If we refuse access, we will tell you in writing and in some circumstances you may ask that a neutral person review the refusal.

2. Right to Amend Your Records. If you feel that your protected health information is incorrect or incomplete, you may ask that we amend your health records. To exercise this right, you must contact the Privacy Officer to complete a specific form stating your reason for the request and other information that we need to process your request. We can refuse your request if we did not create the information, if the information is not part of the information we maintain, if the information is part of information that you were denied access to, or if the

information is accurate and complete as written. You will be notified in writing if your request is refused and you will be provided an opportunity to have your request included in your protected health information.

3. Right to an Accounting. You have a right to an accounting of disclosures of your protected health information that is maintained in a designated record set. This is a list of persons, government agencies, or businesses who have obtained your health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us with the information that we need to process your request. There are specific time limits on such requests. You have the right to one accounting per year at no cost.

4. Right to a Restriction. You have the right to ask us to restrict disclosures of your protected health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us with the information that we need to process your request. If you self-pay for a service and do not want your health information to go to a third party payor, we will not send the information, unless it has already been sent, you do not complete payment, or there is another specific reason we cannot accept your request. For example, if your treatment is a bundled service and cannot be unbundled and you do not wish to pay for the entire bundle, or the law requires us to bill the third party payor (e.g., a governmental payor), we cannot accept your request. We do not have to agree to any other restriction. If we have previously agreed to another type of restriction, we may end that restriction. If we end a restriction, we will inform you in writing.

5. Right to Communication Accommodation. You have the right to request that we communicate with you in a certain way or at a specific location. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us the information that we need to process your request.

6. Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.

7. Right to Obtain the Notice of Privacy Practices. You have the right to have a paper copy of this Notice. You may request a copy from the Privacy Officer or you may go to our website at www.cancercenterofkansas.com.

8. Right to File a Complaint. If you believe your privacy rights as described in this Notice have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services – Office for Civil Rights (Regional Office at Kansas City), 601 East 12th Street Room 248, Kansas City MO 64106, (816) 426-7277, or through www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE:

We reserve the right to change this Notice at any time. We reserve the right to make the revised Notice effective for protected health information that we currently maintain in our possession, as well as for any protected health information we receive, use, or disclose in the future. A current copy of the Notice will be posted in our facility.

IMAD NASSIF, M.D.

Acknowledgement Form

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices of Dr. Imad Nassif, M.D.

Name: _____ **Date:** _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES – FOR IMAD NASSIF, M.D. USE ONLY

The above named Patient/Personal Representative was provided or offered a copy of WEC's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of his/her receipt of the Notice, but such acknowledgement could not be obtained because:

____ Patient/Personal Representative refused to sign.

____ Patient/Personal Representative was unable to sign.

____ The Patient had a medical emergency and an attempt to obtain the acknowledgement will be made at the next available opportunity.

____ Other reason (please specify) _____

_____

Signature of Workforce Member Completing Form:

_____ Date _____

Original to be maintained in Patient's Medical Record

Imad I. Nassif, M.D.

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (4)

Patient's Name: _____ Phone: _____

Home Address: _____ Mailing Address: _____

_____ _____
CITY STATE ZIP CITY STATE ZIP

Birthdate: ____/____/____ Age: ____ M F Social Sec. #: _____ Marital Status: M W S D O
MO DA YR SEX (CIRCLE ONE)

Employer: _____ Phone: (____) _____
NAME OCCUPATION

Spouse: _____ / _____ / _____ Phone: (____) _____
NAME OCCUPATION D.O.B.

Responsible Party: _____ Phone: (____) _____
NAME RELATIONSHIP

Emergency Contact: _____ Phone: (____) _____
NAME RELATIONSHIP

Referring Physician: _____ _____
NAME CITY

Primary Care / Family Physician: _____ _____
NAME CITY

Primary Insurance: _____ Phone: ( ) _____

Insured: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Phone: ( ) _____

Insured: _____ Policy #: _____ Group #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Imad Nassif, M.D. and/or Wichita Endoscopy, LLC (Nassif/WEC). I also authorize agent of any hospital, treatment center or previous physicians to furnish Nassif/WEC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to the patient or designated patient representative(s), any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance within Nassif/WEC.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing I physician services including major medical benefits are hereby assigned to Imad I. Nassif, M.D. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Imad I. Nassif, M.D.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties including (a) managed care companies, insurance companies and other payors; (b) governmental bodies (such as the Food and Drug Administration and the Centers for Medicare and Medicaid Services); (c) federally funded registries; (d) representatives and agents of my health benefit program; (e) persons conducting quality or peer review or patient satisfaction surveys; (f) other clinical and non-clinical parties that have a contractual relationship with Nassif/WEC and (g) my immediate family members.
5. Effective July 15th, 2012 there will be a $50 charge for any office appointment missed, cancelled or rescheduled without 24 hour notice. Procedures require 48 hours notice.

THIS AGREEMENT / CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____ AM or PM
Patient / Responsible Party Signature Date / Time (circle one)

Employee Initial: _____

Imad I. Nassif, M.D., A.G.A.F

Gastroenterology/Hepatology
9050 E. 29th Street N., Suite 100 Wichita, KS 67226
(316) 219-9651 Fax (316) 219-9655

Please fill out this form completely and return it to the front desk along with your health history forms.

Patient Name: ☐ Male ☐ Female			Date of Birth:	
E-mail address: ☐ No E-mail ☐ Not Interested				
Race (check one)	☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Unknown ☐ Not Provided	☐ African ☐ Asian-Indian ☐ Cambodian ☐ Chinese ☐ Eskimo ☐ Fijian	☐ Filipino ☐ Guamanian (Guam) ☐ Hawaiian ☐ Hmong ☐ Japanese ☐ Korean	☐ Laotian ☐ Pakistani ☐ Samoan ☐ Thai ☐ Tongan ☐ Vietnamese
Ethnicity (check one)	☐ Hispanic or Latino	☐ Non-Hispanic or Latino		☐ Not Provided
Preferred Language	☐ English	☐ Spanish	☐ Vietnamese	☐ Other: _____
Did you receive a flu shot this year? Yes or No		If yes, when? Oct. Nov. Dec		
Are you having any pain at this time ☐yes ☐ No		If so, where?	Pain Scale 0-10:_____	
Last Tetanus Shot:		Have you had German Measles or the vaccination?		
Referring Physician:		**Drug Allergies:**		

Medications currently being taken (if more space is needed, use the back of this page).

Drug	Dose	Frequency	Date Started	Reason for Taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Preferred Pharmacy:
(Name and Location)

May we view previous prescription history? ☐ Yes ☐ No

Revised 12/29/2017

Imad I. Nassif, M.D., A.G.A.F.

Gastroenterology/Hepatology
9050 E. 29th, Wichita, KS 67226
(316)219-9651 Fax (316)219-9655

Name _____ **Birthdate:** _____ **Date** _____

Why are you here today? _____

List your illnesses, hospitalizations, operations, and injuries:

DATE	REASON

YOUR FAMILY HISTORY:

Relationship	Age	Any Health Problems
Grandfather		
Grandmother		
Father		
Mother		
Brother/Sister		
Brother/Sister		
Husband/Wife		
Son/Daughter		

Has any blood relative ever had:

Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No		
Heart Trouble	☐ Yes ☐ No	Alcohol Use	☐ Yes ☐ No	Emotional Problems	☐ Yes ☐ No
Bleeding Tendency	☐ Yes ☐ No	Gout/Arthritis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No

Have you had a flu shot this year? ☐Yes ☐No What month (approximately)? _____

Circle one: Single Married Separated Divorced Widowed

Sexual Partner Preference: Male Female Both

Have you been sexually active in the last month? ☐ Yes ☐ No

How many people live in your household? _____

What form of transportation do you use most often? _____

Have you ever used any of the following?

Marijuana ___ Cocaine ___ Heroin ___ Speed ___ Other IV drug ___

Alcoholic Beverages? ☐ Yes ☐ No Amount? _____ Drinks per week

Smoking History (Cigarettes, Cigar, Pipe)	I currently smoke ☐ Yes ☐ No	Number packs/day: _____	No. of years: _____
	I used to smoke ☐ Yes ☐ No	Number packs/day: _____	No. of years: _____ When did you stop? _____
Do you chew tobacco? ☐ Yes ☐ No	I used to chew tobacco ☐ Yes ☐ No	When did you stop?	

Seatbelts? ..... Never Sometimes Almost Always
Sunscreen? ..... Never Sometimes Almost Always
Exercise? ..... Never Sometimes Almost Always
Regular Balanced Meals? ..... Never Sometimes Almost Always
See a dentist regularly? ☐ Yes ☐ No
See an eye doctor regularly? ☐ Yes ☐ No
Employed outside of home? ☐ Yes ☐ No
What is your job? _____
Are you exposed to fumes, dusts or solvents? _____

HAVE YOU HAD ANY OF THESE?

Recent weight change	☐Yes / ☐No	Fast or skipped heartbeat	☐Yes / ☐No
Skin disease	☐Yes / ☐No	Chest pain or heaviness	☐Yes / ☐No
Jaundice (yellow skin)	☐Yes / ☐No	Shortness of breath	☐Yes / ☐No
Hives, eczema, rash	☐Yes / ☐No	Heart trouble / heart attack	☐Yes / ☐No
Moles or skin spots changing	☐Yes / ☐No	High Blood Pressure	☐Yes / ☐No
Eye problems	☐Yes / ☐No	Swelling hands / feet / ankles	☐Yes / ☐No
Wear glasses	☐Yes / ☐No	Awakening in night smothering	☐Yes / ☐No
Double vision	☐Yes / ☐No	Heart Murmur	☐Yes / ☐No
Headaches	☐Yes / ☐No	Blood clots	☐Yes / ☐No
Nosebleeds	☐Yes / ☐No	Anemia	☐Yes / ☐No
Sinus trouble	☐Yes / ☐No	Peptic Ulcer	☐Yes / ☐No
Ear Problems	☐Yes / ☐No	Vomiting	☐Yes / ☐No
Hearing Loss	☐Yes / ☐No	Gallbladder disease	☐Yes / ☐No
Dizziness	☐Yes / ☐No	Liver trouble	☐Yes / ☐No
Trouble swallowing / hoarseness	☐Yes / ☐No	Hepatitis	☐Yes / ☐No
Neck stiffness	☐Yes / ☐No	Bleeding with bowel movement	☐Yes / ☐No
Thyroid trouble	☐Yes / ☐No	Black Stools	☐Yes / ☐No
Swollen glands	☐Yes / ☐No	Change in bowel habits	☐Yes / ☐No
Coughing	☐Yes / ☐No	Diarrhea	☐Yes / ☐No
Asthma / wheezing	☐Yes / ☐No	Heartburn or indigestion	☐Yes / ☐No
Problem breathing	☐Yes / ☐No	Cramping or pain in abdomen	☐Yes / ☐No
Any trouble with lungs	☐Yes / ☐No	Weakness in Muscles	☐Yes / ☐No
Can't control bladder	☐Yes / ☐No	Stiff or Painful Joints	☐Yes / ☐No
Urinating more often	☐Yes / ☐No	Hot / Cold Flashes	☐Yes / ☐No
Night-time urinating	☐Yes / ☐No	Do you find it hard to make decisions?	☐Yes / ☐No
Burning or painful urination	☐Yes / ☐No	Do you have any memory loss?	☐Yes / ☐No
Blood in Urine	☐Yes / ☐No	Do you have difficulty relaxing?	☐Yes / ☐No
Kidney Infection	☐Yes / ☐No	Do you lose your temper often?	☐Yes / ☐No
Kidney Stones	☐Yes / ☐No	Are you having any sexual problems?	☐Yes / ☐No
Sexually Transmitted Disease	☐Yes / ☐No	Do you feel lonely or depressed?	☐Yes / ☐No
Convulsions / Seizures	☐Yes / ☐No	Do you feel tired most of the time?	☐Yes / ☐No
Fainting spells	☐Yes / ☐No	Do you have any trouble with sleep?	☐Yes / ☐No
Shaking or Trembling	☐Yes / ☐No	Have you ever considered suicide?	☐Yes / ☐No

Do you consider your health: Excellent Good Fair Poor

FOR MEN ONLY:
Last testicular exam _____ Last Prostate exam _____

FOR WOMEN ONLY:
Age period started: _____
How long do periods last? _____ days
How often are periods? Every _____ days
Any pain with periods? ☐Yes ☐No
First day of last period _____
Vaginal discharge? ☐Yes ☐No
Check your breasts monthly? ☐Yes ☐No
Breast Lump or nipple discharge? ☐Yes ☐No
Number of pregnancies _____
Number of miscarriages/abortions _____
Number of Children _____ Ages _____
Date of last pap smear and results _____
_____
Last mammogram (breast exam) _____