East Tennessee Colon and Rectal Surgical Associates, P.C.

Jay A. Young, M.D., F.A.C.S. **Daniel D. Opheim, M.D.**

10810 Parkside Drive
Suite 201
Knoxville, TN 37934
865-392-9220

7323 Chapman Highway.
Suite 100
Knoxville, TN 37920
865-392-9220

Fax: 865-392-9221
Website:
www.etcrs.com

Satellite Locations:
Morristown
Newport

This is to confirm your appointment with us on _____
Enclosed are forms for you to fill out and bring with you on the day of your appointment.

- Please bring a complete list of ALL of the medications that you currently take. We need the complete name, dosage and how often you take them.
- You may eat and take your medications as usual before your visit.
- Please bring any medical records, CT's or X-Rays with you that pertain to the condition we are evaluating. If we do not have these on the day of your visit, it may cause a delay in your treatment.
- Please bring your current insurance card(s) with you and a photo ID.
- **Check with your insurance company to be sure that they do not require a referral number from your Primary Care Physician PRIOR to your visit.** It is the patient's responsibility to obtain the referral. If Prior authorization is required, we will not be able to see you without the referral number.
- If you do not have insurance coverage, please bring $250-$300 for your first visit. Any future appointments, surgeries, or procedures must be paid for in advance. We apologize for any inconvenience.
- **It WILL be necessary for you to use 2 Fleet enemas prior to your visit due to the possibility of a rectal exam.** (Unless we have instructed you otherwise OR if you have an ileostomy/colostomy). These may be obtained at any local pharmacy department. Instructions will be inside the box. Use the first enema, then evacuate, and then use the second enema. Finish these about one hour before you leave home.

Call our main office number for all locations.
(865) 392-9220

Offices in the following locations:

WEST KNOXVILLE: 10810 Parkside Drive, Suite 201, Knoxville, TN, 37934
Physicians Plaza 1 at Tennova Turkey Creek Hospital. Located next to Walmart in Turkey Creek Shopping Center. Go through the main entrance of the hospital. We are located on the 2nd floor, directly beside Elevator A in the Physicians Plaza 1.

TENNOVA SOUTH: 7323 Chapman Highway Suite 100, Knoxville, TN 37920
Located across from Walmart and behind Pizza Hut.

NEWPORT: 434 4th Street, Suite 301 Cocke Co.Prof.Bldg., Newport, TN, 37821
Located behind the Newport Medical Center. Dr. Young only.

MORRISTOWN: 823 McFarland Street, Morristown, TN, 37814
At the location of Hamblen Family Medicine/ Dr. Frederick Yarid's office
(at top of hill - which is near the previous Lakeway Regional Hospital).
Dr. Opheim only.

EAST TENNESSEE COLON & RECTAL SURGICAL ASSOCIATES

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all the charges for services for which I am about to receive. I will be financially responsible for any services not covered by my insurance company for any reason, including co-payments, co-insurance and deductibles. I understand if I have not secured the appropriate referrals and authorizations and otherwise followed the terms of my health plan benefits, there may be a decrease in my coverage or no coverage at all for some or all of the services which I am about to receive. If I have no insurance, I understand that I will be financially responsible for all services provided at the time of service. I understand that there is the likelihood of a rectal exam, proctoscope, anoscopy, or in-office procedure and that some insurance companies apply this to my deductible.

Patient or Guardian's Signature _____

INSURANCE AUTHORIZATION AND RELEASE

I request that payment of authorized benefits (including Medicare, and any other government sponsored program, private insurance, and any other health plans) be made to **East Tennessee Colon & Rectal Surgical Associates, P.C.** for any services furnished by that provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize **East Tennessee Colon & Rectal Surgical Associates, P.C.** to act as my agent to help me obtain any required precertification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give **East Tennessee Colon & Rectal Surgical Associates, P.C.** any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature _____ Date _____

MEDICARE/MEDIGAP AUTHORIZATION

ONE-TIME MEDIGAP ASSIGNMENT AND RELEASE

I request that payment of authorized Medicare and if applicable, Medigap benefits be made on my behalf to **East Tennessee Colon & Rectal Surgical Associates, P.C.** for services furnished to me by them. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid services, my Medigap insurer and their agents any information needed to determine these benefits payable for related services. This will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient's Signature _____ Date _____

MEDICAL RECORDS RELEASE

I hereby authorize East Tennessee Colon & Rectal Surgical Associates, P.C. to release any information in my chart to any practitioner, doctor, hospital, medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital or medical institution to assist in my care.

Patient's Signature _____Date _____

OFFICE EXAMINATION

I Consent to have an examination by Dr. Young and Dr. Opheim. This may include an anorectal exam, proctoscopy and/or flexible sigmoidoscopy. I understand that the Physician will discuss this with me including the possibility of pain, cramping, bleeding and the remote possibility of perforation, which would require surgery.

Patient's Signature _____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of East TN Colon & Rectal Surgical Associates Notice of Privacy Practices. This Notice describes how East TN Colon & Rectal Surgical Associates may use and disclose my protected health information, certain restrictions on the use and disclosures of my healthcare information, and rights I may have regarding my protected health information.

Patient's Signature _____Date_____

East TN Colon & Rectal Surgical Associates, P.C.

Jay A. Young, M.D.,F.A.C.S. Daniel D. Opheim, M.D.

Patient Information

Full Legal Name_____Date of Visit_____
Address_____City_____State_____ZIP_____
Home Phone(___) _____Cell Phone(___)_____
Email_____
Date of Birth_____Age_____Social Security Number_____
Marital Status: □ Married □Single □Widowed □ Divorced Sex: □ Male □ Female
Employer_____Retired from_____Work Phone(___)_____

Please choose preference for receiving communication from our office □ Phone □Email □USPS □Fax_____

Ethnicity □ Non Hispanic/Latino □ Hispanic/Latino **Preferred Language**_____
Race: □ White □ Black/African American □American Indian □ Alaska Native □ Asian □ Native Hawaiian □ Pacific Islander

Insurance Information

Primary Insurance:_____ Secondary Insurance:_____
ID #_____ Network □S □ P ID #_____ Network □ S □ P
□ PPO □POS □HMO □ Open Access □ PPO □POS □HMO □ Open Access

Is this coverage through your
□ Employer □ Retirement Plan □.Family members employer

Is this coverage through your
□ Employer □ Retirement Plan □.Family members employer

Subscribers Name:_____ DOB _____SSN_____
Place of employment_____Relationship to patient_____

Contact

Emergency Contact Information_____
Phone #_____Relationship_____

Complaint

Reason for coming to office today or complaints_____
Family Physician_____Address_____
Full Name
Who referred you to our practice? _____
Is this a…….. □ Physician □ Family Member □ Friend □ Other Source □ Phone Book □ ER □ Internet

Medications, Allergies, and Conditions

List Current Medications with dosage and how often you take them. □ see attached list

(name) (dosage) (how often) (name) (dosage) (how often)

1._____2._____
3._____4._____
5._____6._____

Pharmacy Name_____Location_____
Pharmacy Phone #_____

List allergies to medicines with reaction_____
Are You allergic to Latex, Iodine, or X-ray Dye_____
Do you have a pain contract with another physician? Yes or No
Flu Shot: Yes or No When?_____ **Pneumonia Shot**: Yes or No When?_____
Have you ever had a colonoscopy? Yes or No When was most recent? _____

Circle Yes or No if you have had any of the following:

High Blood Pressure	Y N	_____	Diabetes	Y N	_____
Heart Trouble	Y N	_____	Stroke	Y N	_____
Bleeding Problems	Y N	_____	HIV/AIDS	Y N	_____
Kidney Disorders	Y N	_____	Heart Murmur	Y N	_____
Colon Disorders	Y N	_____	Cancer	Y N	_____
Other Illnesses	Y N	_____			

NAME:_____**DOB**_____**Date of Service:**_____

PLEASE LIST PAST SURGERIES, HOSPITALIZATIONS OR INJURIES:

Operations/Illness Date Physician/Hospital

_____

_____

_____

_____

CHILDBIRTH INFORMATION:

List dates and types of delivery: (vaginal delivery or c-section) _____

_____

FAMILY HISTORY:

Please list any medical problems in your relatives:

Father_____ Mother_____

Siblings_____

Children_____

SOCIAL HISTORY:

Tobacco Use ☐ Smoker ☐ Current Every Day Smoker ___ packs____per day ☐ Current Some Day Smoker
☐ Former Smoker ☐ Never Smoker ☐ Current Status Unknown ☐ Unknown if Ever Smoked

Alcohol Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily How much? _____

Drug Use ☐ Never ☐ Past History/ Quit when? Type? _____ ☐ Current Drug User

How often do you have a bowel movement ? _____

Do you use laxatives ? Y N How often/What kind ? _____

REVIEW OF SYSTEMS: Please circle:

☐ **Constitutional**		☐ **ENT**		☐ **Eyes**	
Good General Health	Y N	Hearing loss or ringing	Y N	Wear glasses/contacts	Y N
Recent weight change	Y N	Sinus problems	Y N	Blurred/Double vision	Y N
Night sweats, fevers	Y N	Nose bleeds	Y N	Eye disease or injury	Y N
Fatigue/Weakness	Y N	Sore throat	Y N	Glaucoma	Y N

☐ **Cardiovascular**		☐ **Respiratory**		☐ **Musculoskeletal**	
Chest pain	Y N	Shortness of breath	Y N	Muscle pain or cramps	Y N
Palpitations	Y N	Cough	Y N	Stiffness/swelling joints	Y N
Heart trouble	Y N	Wheezing/Asthma	Y N	Joint Pain	Y N
Swelling hands/feet	Y N	Coughing up blood	Y N	Trouble walking	Y N

☐ **Neurological**		☐ **Integumentary (Skin/Breast)**		☐ **Endocrine**	
Frequent headache	Y N	Change in hair or nails	Y N	Excessive thirst/urination	Y N
Paralysis or tremors	Y N	Rashes or itching	Y N	Thyroid disease	Y N
Convulsions/seizures	Y N	Breast lump	Y N	Hormone problem	Y N
Numbness/tingling	Y N	Breast pain/discharge	Y N		

☐ **Hematologic/Lymphatic**		☐ **Psychiatric**		☐ **Genitourinary**	
Bruise easily	Y N	Insomnia	Y N	Blood in Urine	Y N
Slow to heal	Y N	Confusion/memory loss	Y N	Kidney stones	Y N
Enlarged glands	Y N	Depression	Y N	Testicle pain	Y N
				Menstrual pain	Y N

☐ **Gastrointestinal**

Nausea/vomiting	Y N	How long? _____
Abdominal Pain	Y N	How long? _____
Pain w/ bowel movement	Y N	How long? _____
Unable to control gas	Y N	How long? _____
Unable to control BM	Y N	How long? _____
Constipation/diarrhea	Y N	How long? _____
Diarrhea	Y N	How long? _____
Awakened by rectal pain	Y N	How long? _____
Rectal burning	Y N	How long? _____
Rectal bleeding	Y N	How long? _____

- **To the best of my knowledge, this information is correct and accurate. I authorize the release of medical information necessary to process my insurance claims. I authorize payment of insurance benefits to the Physician.**

SIGNED X_____

I have reviewed with patient:

_____MD

EAST TENNESSEE COLON & RECTAL SURGICAL ASSOCIATES

1. My preferred method of contact is

☐ No Preference
☐ Phone _____
☐ Email _____
☐ Postal
☐ Patient Portal

2. I prefer my appointment notification contact method to be

☐ No Preference ☐ Do Not Call ☐ Email _____
☐ Text Mobile _____ ☐ Call Primary Phone_____
☐ Call Other #_____ ☐ Call Work phone_____

3. You will receive an enrollment for patient portal. If you would like to access your records online please follow the steps in the email to sign up.

4. East Tennessee Colon & Rectal Surgical Associates has my permission to speak with my family members or others listed below concerning my Protected Health Information.

_____ _____

_____ _____

5. If you do not want any information given to certain family members, please list them below.

_____ _____

_____ _____

_____ _____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW EAST TN COLON & RECTAL SURGICAL ASSOCIATES MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

East TN Colon & Rectal Surgical Associates is required by law to maintain the privacy and security of your protected health information. This information consists of all records related to your health, including demographic information, either created by East TN Colon & Rectal Surgical Associates or received by East TN Colon & Rectal Surgical Associates from other healthcare providers. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. East TN Colon & Rectal Surgical Associates will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

East TN Colon & Rectal Surgical Associates reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office or on our website at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

East TN Colon & Rectal Surgical Associates may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:
- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultation between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, East TN Colon & Rectal Surgical Associates may determine that you require the services of a specialist. In referring you to another doctor, East TN Colon & Rectal Surgical Associates may share or transfer your healthcare information to that doctor.

Payment activities may include:
- Activities undertaken by East TN Colon & Rectal Surgical Associates to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provide to you.

For example, East TN Colon & Rectal Surgical Associates will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:
- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities.
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, East TN Colon & Rectal Surgical Associates may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared in patients in similar situations.

East TN Colon & Rectal Surgical Associates may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when East TN Colon & Rectal Surgical Associates is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

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[1] This Notice prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- To workers' compensation.
  We may disclose your health information to the extent such records are reasonable related to any injury for which workers compensation is claimed.

East TN Colon & Rectal Surgical Associates will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that East TN Colon & Rectal Surgical Associates has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You have the right to request confidential communications. You may ask us to contact you in a specific way (for example, home or office phone). These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply, if the alternate of communication incurs additional cost, the cost will be passed on to you. We will say "yes" to all reasonable requests.

You have the right to request restrictions on how your protected health information is used for treatment, payment, and health 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 healthcare 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. We must have your restriction documented prior to initiating the service.

You have the right to review and/or obtain an electronic or paper copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. East TN Color & Rectal Surgical Associates may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You have the right to request that East TN Colon & Rectal Surgical Associates amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by East TN Colon & Rectal Surgical Associates for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with East TN Colon & Rectal Surgical Associates and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with East TN Colon & Rectal Surgical Associates, please contact the Privacy Officer at the following:

Privacy Officer
East TN Colon & Rectal Surgical Associates
10810 Parkside Drive , Suite G12
Knoxville, TN 37934

It is the policy of East TN Colon & Rectal Surgical Associates that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

BOWEL CONTROL SATISFACTION SURVEY

Name _____ **Phone** _____

Physician _____

Which symptoms best describe you?

- ☐ Bowel accidents because I am unable to make it to the bathroom in time
- ☐ Bowel accidents while asleep/ unaware
- ☐ Frequent loose, watery stools
- ☐ Abdominal pain

How long have you had these symptoms? _____

Approximately how many bowel accidents do you have per week? _____

Behavior modifications tried _____
(i.e., lifestyle changes, fiber, diet changes, pelvic floor muscle training/biofeedback)

Have you tried medications to help your symptoms? ☐ Yes ☐ No

If yes, check the medications you have tried:

☐ Imodium®
☐ Imotil®
☐ Loperamide
☐ Lomotil®
☐ diphenoxylate
☐ Other _____

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

If you've stopped taking your meds, explain why:

☐ Did not help ☐ Side effects ☐ Too expensive

Describe side effects _____

What is your level of frustration with your bowel control symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not frustrated ***Very frustrated***

I am interested in learning more about other treatment options. ☐ Yes ☐ No

BLADDER SATISFACTION SURVEY

Name_____ Phone #_____

Doctor _____

Which symptoms best describe you?

☐Frequent Urination – Day, Night, or Both ☐Leaking with Sneezing, Coughing, Exercising

☐Sudden or Strong Urge to urinate ☐Leaking with Urge or No Warning (Unable to make it to the bathroom in time)

☐Unable to Empty the Bladder ☐Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? ☐Yes ☐No

If yes, check the medications you have tried:

☐Detrol LA ☐Ditropan XL ☐Flomax ☐Cardura

☐Oxytrol Patch ☐Enablex ☐Vesicare ☐DDAVP

☐Sanctura ☐Elavil ☐Elmiron ☐ Toviaz Gelnique

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

If you've stopped taking your meds explain why:
☐Did not Help ☐Side Effects ☐Too Expensive

Describe Side Effects _____

Behavior Modifications Tried_____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated **Very Frustrated**

I am interested in learning more about treatment alternatives to medications:
☐Yes ☐No

Are you having any trouble with your bowels? **Circle** Yes No