Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS CAREFULLY

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and healthcare options. Protected health information is the information that we create and obtain in providing our services to you. Such information may include documenting your symptoms; examination and test results, diagnoses, treatment and applying for future care treatment. This also includes billing documents for those services rendered by the physician(s) of Franklin Gastroenterology.

Example:

- A nurse or medical assistant obtains treatment information about you and records it in a health record (i.e. paper record and electronic record).
- During the course of your treatment, the physician determines whether he/she will need to consult with another specialist in the area.
- We submit requests for payment to your health insurance company, unless otherwise authorized by you to be a self-pay patient. In this case you will be charged for the services rendered by the physician.

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

May we the staff of Franklin Gastroenterology PLLC, Wilmot C. Burch MD, Rachel Wagner, APN and/ or Franklin Surgery Center leave a message on your **home number, cell number or via the patient portal system;** regarding appointment reminders, normal test results or insurance payment information? _____ Yes _____No

May we the staff of Franklin Gastroenterology PLLC, Wilmot C. Burch MD, Rachel Wagner, APN and/or Franklin Surgery Center leave a message regarding any of the above with anyone other than you at your **home number**? _____Yes _____ No

Would you like for the staff of Franklin Gastroenterology PLLC, Wilmot C. Burch MD, Rachel Wagner, APN and/or Franklin Endoscopy Center to **file your insurance for the services rendered by the physician**?

_____Yes _____No

Please list the name(s) and relationship of the person(s) that we may discuss your medical condition.

Name	Relationship
_____	_____
_____	_____

A full copy of our office's Notice of Privacy Practices is available upon request.

Patient Signature: _____ Date: _____

Patient Printed Name: _____