

**SAMUEL MOURANI, MD**  
Diplomate: American Board of Gastroenterology,  
American Board of Internal Medicine

**ELIAS A. TARAKJI, MD, FACG**  
Diplomate: American Board of Gastroenterology,  
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**Valley Gastroenterology**  
**Consultants** Medical Center, Inc.

488 E. Santa Clara St. • Suite 103 • Arcadia, CA 91006  
Tel 626.359.3330 • Fax 626.359.3339

[www.valley-gastro.com](http://www.valley-gastro.com)

415 W. Carroll Ave. • Suite 201 • Glendora, CA 91741  
Tel 626.963.2490 • Fax 626.963.2495

Dear Friend,

Welcome to Valley Gastroenterology Consultants, with Dr. Samuel Mourani and Dr. Elias Tarakji as its leading physicians! We are dedicated to providing you with the highest quality medical care and delivering you the best results!

For your first visit to our office, you will need to fill out and bring with you the necessary paperwork and items that are listed below:

- 1. A current list of any medications you may be taking.**
- 2. Copies of any recent laboratory or imaging tests (CT scan, Ultrasound, MRI) and prior Colonoscopy or Endoscopy reports you may have had done.**
- 3. Please fill out the front and back of the enclosed Patient Information Sheet completely.**
- 4. Please read and fill out the Privacy Practices/HIPAA documents. There are a total to 2 to fill out, and 2 for you to read and keep for your own records.**
- 5. Please bring all of the completed forms, your insurance card, and a photo ID to your scheduled appointment.**

If you have any questions or concerns before your appointment, please feel free to contact either our Arcadia office at 626-359-3330 or our Glendora office at 626-963-2490. We look forward to meeting with you and listening to your concerns at your upcoming appointment!

Sincerely,

Samuel Mourani, MD  
Elias Tarakji, MD, FACG

**VALLEY GASTROENTEROLOGY CONSULTANTS MEDICAL CENTER, Inc.**  
**PATIENT INFORMATION**

NAME: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

CELL PHONE: (\_\_\_\_) \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

SEX: M F MARTIAL STATUS (circle one): SINGLE MARRIED DIVORCE WIDOW (ER)

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

**PATIENT'S EMPLOYER INFORMATION**

COMPANY: \_\_\_\_\_ WORK PHONE: (\_\_\_\_) \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

**INSURANCE INFORMATION Please Circle One HMO PPO POS EPO**

**PRIMARY INSURANCE COMPANY:** \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ INS. PHONE: (\_\_\_\_) \_\_\_\_\_

SUBSCRIBERS NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:** \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ INS. PHONE: (\_\_\_\_) \_\_\_\_\_

SUBSCRIBERS NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

**WHOM MAY WE CONTACT IN THE CASE OF AN EMERGENCY?**

NAME: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU TO US?**

NAME: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

OFFICE POLICY ON PAYMENT:

I UNDERSTAND AND AGREE THAT CO-PAYS ARE DUE AT THE TIME OF VISIT AND (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND AND I WILL NOTIFY YOU OF ANY CHANGES IN MY INSURANCE STATUS. **LABORATORY, RADIOLOGY, AND OTHER ANCILLARY SERVICES PROVIDED IN CONNECTION WITH PHYSICIANS OFFICE ARE SEPARATE.**

INSURANCE POLICY:

INSURANCE PROVIDES FOR REIMBURSEMENT ON ALLOWED MEDICAL CHARGES. WE WILL SUBMIT TO MOST INSURANCE CARRIERS, IF YOU HAVE PROVIDED US WITH ALL PERTINENT INFORMATION. YOU ARE RESPONSIBLE FOR ALL CO-PAYS, DEDUCTIBLES AND CHARGES NOT COVERED BY YOUR INSURANCE. PLEASE UNDERSTAND THAT WE CANNOT, AS A THIRD PARTY, BECOME INVOLVED IN PROLONGED INSURANCE NEGOTIATIONS, THIS IS YOUR RESPONSIBILITY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. EITHER MY INSURANCE COMPANY OR MYSELF MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I AUTHORIZE THE DOCTOR TO RELEASE ANY MEDICAL INFORMATION INCLUDING DIAGNOSIS, X-RAY, TEST RESULTS, REPORTS AND RECORDS PERTAINING TO ANY TREATMENT OR EXAMINATION RENDERED TO ME. I UNDERSTAND THAT THIS MEDICAL INFORMATION MAY BE USED FOR ANY OF THE FOLLOWING PURPOSES: DIAGNOSTIC, INSURANCE, LEGAL, AND AT TIMES WHEN THE COSTOR DEEMS IT NECESSARY IN ORDER TO ENSURE THE BEST MEDICAL CARE ON MY BEHALF. I FURTHER UNDERSTAND THAT ANY PERSON(S) THAT RECEIVE THESE MEDICAL RECORDS WILL NOT RELEASE ANY OF THE MEDICAL INFORMATION OBTAINED BY THIS AUTHORIZATION TO ANY OTHER PERSON OR ORGANIZATION WITHOUT A FURTHER AUTHORIZATION SIGNED BY ME FOR RELEASE OF THE INFORMATION.

I HAVE READ THE ABOVE AND ACCEPT FINANCIAL RESPONSIBILITY IN FULL FOR THIS ACCOUNT.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



# **NOTICE OF PRIVACY PRACTICES**

VALLEY GASTROENTEROLOGY CONSULTANTS MEDICAL CENTER  
488 E. SANTA CLARA ST., SUITE 103  
ARCADIA, CA 91006

***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.***

This notice takes effect on APR 14, 2003 and remains in effect until we replace it.

## **1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

## **2. OUR LEGAL DUTY**

### ***Law Requires Us to:***

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

### ***We Have the Right to:***

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

### ***Notice of Change to Privacy Practices:***

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

## **3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purposes not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

## NOTICE OF PRIVACY PRACTICES

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

**Facility Directory:** Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for you religious affiliation, to others who contact us and ask for information about you by name.

**Notification:** Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

**Disaster Relief:** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Fundraising:** We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of you health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

**Research in Limited Circumstances:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

**Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

## **NOTICE OF PRIVACY PRACTICES**

***Victims of Abuse, Neglect, or Domestic Violence:*** We may disclose medical information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

***Workers Compensation:*** We may disclose medical information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

***Health Oversight Activities:*** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

***Law Enforcement:*** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

### **4. YOUR INDIVIDUAL RIGHTS**

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$1.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposed other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create that information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

### **QUESTIONS AND COMPLAINTS**

If you have any questions about this notice or if you think that we may have violated privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S Department of health and Human Services. We will not retaliate in any way if you choose to file a complaint.

# **PRIVACY PRACTICES ACKNOWLEDGEMENT**

## **ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**What is your Mother's Maiden name?**

