ADVANCED GASTROENTEROLOGY & Surgery Associates

PATIENT INFORMATION

Please review your information on file and update as necessary:
Last: First: Middle: Social Security: _____ Age: ___ Birth Date: _____

Local Address: City: State: Zip:
Home Phone: Cell Phone: Work Phone:
E-mail:
EMERGENCY CONTACT: Relationship: EMERG Phone Number:

PER FLORIDA STATUTES, WHAT BEST DESCRIBES YOU: Sex: M/F **Marital Status**: Married Divorced Single Widowed
Ethnicity: Hispanic or Latino/Spanish Puerto Rican Not Hispanic/Not Latino Other Decline
Race: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander White Other Decline

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INSURANCE:

Primary Ins. Co Name: Policy #:

Relationship to the insured: Self Spouse Child Other

Spouse's name if Insured/Parent (if minor): Birth Date: Social Security #

Secondary Ins. Co Name: Policy #:

HOW DID YOU HEAR ABOUT US? Primary Care Physician Specialist Physician Family/Friend I'm a prior patient Hospital Insurance Co. Billboard/Sign Website Magazine:_____ Newspaper:_____ Other:_____

PHARMACY/LAB/IMAGING INFORMATION

_____ _____
PREFERRED PHARMACY Location: Street/City or Phone **OTHER PHARMACY** Location: Street/City or Phone

_____ _____
LAB PREFERENCE Location: Street/City or Phone **IMAGING PREFERENCE** Location: Street/City or Phone

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CLINICAL PROVIDERS ON FILE

_____ _____
REFERRING PROVIDER Phone # PRIMARY CARE PROVIDER Phone #

_____ _____
OTHER PHYSICIAN PARTICIPATING IN YOUR CARE Phone # OTHER PHYSICIAN PARTICIPATING IN YOUR CARE Phone #

I certify the information that I provided is correct. I authorize the release of medical information necessary to process insurance claims to my insurance companies or their agencies (including Medicare), for the purpose of the filing and payment of medical claims. I authorize payment of medical benefits to the provider I permit a copy of this release to be used in place of the original.

Signature: _____ **Date: _____**

BILLING & HEALTH INSURANCE POLICIES

CANCELLATION POLICY Our office has a cancellation/no show policy in which you will be charged $50 for failing to cancel or reschedule your office appointment 24 hours in advance. Failing to show or cancel for a scheduled surgery, e. g. colonoscopy, EGD, hernia repair, will incur a $100 charge. Please make every attempt to call the office and notify us of any changes or emergencies that may interfere with your scheduled appointment with us. The time scheduled for your appointment is assigned to you and you alone.

FINANCIAL OBLIGATIONS All co-payments are due when services are rendered. Deductibles and co-insurances may also be collected at this time. Outstanding balances on your account, over 45 days, may require payment before additional services are rendered.

INSURANCE CLAIM FILING We file your Insurance claims as a courtesy to you and, in most cases, provide services in good faith, prior to getting payment. If your insurance company does not respond within 60 days from the date of filing, then the balance will be transferred to you and will become your responsibility.

PATIENT STATEMENTS You will receive a monthly statement and payment is due upon receipt. If payment is not received, or if no response to the statement is received within 45 days, further action, including outside collection agency involvement may be taken. In the event that you have a procedure performed at Lake Surgery and Endoscopy Center or Endosurg Outpatient Center, please be advised that you will receive three separate statements.

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is available in the office and posted on wall.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc, those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes in office policy and new technology that you might find valuable or informative insurance items, and items pertaining to your clinical care such as: laboratory and pathology results, diagnostic results, among others.

3. I understand that my physician may need access to my medication history and may work in conjunction with my pharmacy and/or insurance carrier in order to provide accurate medical treatment.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. We agree to provide patient with access to their medical records in accordance with state and federal laws.

7. We may change, add, delete, or modify and of these provisions to better serve the needs of both the patient and the practice.

8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to your request.

9. I authorize the following people to be able to receive information regarding my medical condition:

   _____Relationship_____

   _____Relationship_____

   _____Relationship_____

By my signature below, I am acknowledging my review and understanding of the above BILLING & HEALTH INSURANCE POLICIES and HIPAA INFORMATION & CONSENT on the date set forth below.

Patient Signature _____

NOTE: If patient is unable to sign or is a minor, please sign below:

Closest Relative or Legal Guardian's Signature _____

Witness _____

To ensure Medicare beneficiaries receive the information and help needed to understand your Medicare options and Medicare rights and protections, you may contact the Office of the Medicare Beneficiary Ombudsman.

PATIENT HEALTH INFORMATION

Patient signature: _____ Date: _____

Past Medical History

Please circle if you have ever had any of the following:

Atrial Fibrillation	Chronic blood thinner	Gallstones	Irregular heart	Paralysis
Anal Fissure	Congestive heart failure	Glaucoma	Jaundice	Parkinson's
Angina	Coronary artery disease	Headaches	Kidney stones/failure	Pancreatitis
Asthma	Depression	Heart murmur	Liver disease	Seizures
Back problems	Diabetes	Heart valve problems	Lungs/breathing	Stroke/mini-stroke
Bleeding problems	Dizziness	Hepatitis	MRSA	Thyroid
Bronchitis	Emphysema	High blood pressure	Nerves	Tuberculosis
Cancer_____	Eye disease	High cholesterol	Obstructive Sleep Apnea	
_____	Fainting	HIV	Palpitations	**[ ] none of the above**

Other: _____

Past Surgical History

Please circle all previous surgeries that you have had:

Angioplasty	Cataract	Hemorrhoidectomy	Knee surgery	Surgery for adhesions
Appendectomy	Cesarean	Hernia	Neck surgery	Tonsillectomy
Arm or hand surgery	Colon surgery	Hiatal hernia repair	Pacemaker	Tubal ligation
Back surgery	D&C	Hip surgery	Prostate surgery/TURP	Vasectomy
Breast surgery (R) (L)	Gall bladder	Hysterectomy	Rotator cuff	
Bunionectomy	Heart surgery	Jaw surgery	Sinus surgery	**[ ] none of the above**

Other: _____

List ALL medications-prescription, nonprescription, supplements, and herbs (please list dose and frequency)

_____

_____

_____

ALLERGIES with reaction and date presented (If no allergies, please write NONE):

_____

_____

Your height: _____ ft _____in **Your weight:** _____lbs **Your date of birth:** _____

Please circle either Yes or No

Yes No Do you take aspirin, Ticlid, Coumadin, Plavix, or any kind of blood thinner on a regular basis?

Yes No Do you have trouble breathing? (Please circle what applies) Lying down At rest On exertion

Yes No Have you or any blood relative ever had a problem with an anesthetic? (Please circle you or relative)

Yes No Do you have any problem with your memory or speech?

Yes No Do you have an arm or leg that is weak or becomes weak?

Yes No Do you have any of the following? (Please circle what applies) Dentures, Bridge work, Capped tooth, Chipped tooth

Yes No Is it possible that you are pregnant? Last menstrual period_____

Yes No Do you wear contact lenses, hearing aids, and limb or eye prosthesis? (Please circle)

Yes No Do you have any problems with or have had surgery involving your neck, jaw, hip, knee, or back? (Please circle)

Social history

Yes No Do you or did you ever consume alcohol? Drinks_____per week. How long? _____years. Quit? _____

Yes No Have you ever smoked? Pack a day_____. How long?_____years. Quit_____years ago.

OFFICE USE ONLY – ANESTHESIA

Airway Class: M.P. I II III IV Respiratory: LCTA: Y N_____

NPO: _____ Cardiac murmur: Y N RRR IR_____

Laboratory: Normal: Y N None: _____

ASA Class I II III IV Risks/Benefits discussed

Anesthesia Plan: MAC IV Sedation General ET LMA MASK Regional

Anesthesia Signature: _____

Heart _____ Lungs _____ Surgical Risk Acceptable: YES NO Cleared For Surgery: YES NO

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CURRENT SYMPTOMS

Patient signature:_____ Date:_____

Please circle any of the following problems that you may <u>have or have had recently.</u>

Abdominal pain	Anemia	Black stools	Change in bowel habits	Chest pain	Chronic cough
Constipation	Diarrhea	Difficulty swallowing	Fecal incontinence	Fecal urgency	Fever
Hiatal hernia	Hoarseness	Indigestion	Loss of appetite	Nausea	Painful swallowing
Rectal bleeding	Sore throat	Vomiting	Vomiting blood	Weight loss	**[ ] none of the above**

Feeling of food or pills stuck in throat

Yes **No** Have you ever had a colonoscopy, sigmoidoscopy, or Barium Enema? If yes, when? _____ where?_____

Yes **No** Have you ever had an EGD (gastroscopy) or upper GI (Barium Swallow)? If yes, when? _____ where?_____

Father died of_____ at age _____ yrs. **[ ] Father living**

Mother died of_____ at age _____ yrs. **[ ] Mother living**

Please circle Y for those that either applies to <u>you</u> and/or **<u>your family</u> (on both your mother's or father's side). Next to each statement, please list the relationship to you and age of diagnosis and age of death if indicated. You and the following family members should be considered:** *Mother Father Brother Sister Maternal Uncle/ Aunt Paternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/ Grandfather Paternal Grandmother/Grandfather*

	COLON AND UTERINE CANCER	**Self**	**Family Member**	**Age of Diagnosis**	**Age of Death**
Y	Colorectal (colon, rectum) cancer before the age of 50				
Y	Uterine (endometrial) cancer before age 50				
Y	Two or more Lynch syndrome cancers* in the same person or on the same side of family				
Y	Colorectal (colon, rectum) cancer after the age of 50				
Y	Colon polyps				
Y	Cancer of liver, stomach or pancreas				
	POLYPOSIS SYNDROMES				
Y	10 or more cumulative (over lifetime) colorectal adenomas (colon polyps)				
	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain: . .				
Y	**None of the above apply to <u>you and/ or your family</u>**				

*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal, pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas

We know we already asked you this, but would you kindly write the names of your physicians one more time? Thank you

Referring Physician:

_____

Other Physician participating in your care:

_____

Primary Physician:

_____

Other Physician participating in your care:

_____