Advanced Gastroenterology of Central Florida

PATIENT INFORMATION

Last Name_____ First Name_____ DOB: _____

Gender:_____ Email _____Cell Phone_____

Address_____ City_____ State_____ Zip_____

Primary Doctor: _____

Preferred Pharmacy Name / Phone/ address: _____

_____

Emergency Contact _____ Relationship _____ Phone _____

Primary Insurance

Name of Insurance _____ Policy# _____ Group# _____

Secondary Insurance

Name of Insurance _____ Policy# _____ Group# _____

How did you hear about us? _____

Please note that it is your responsibility to obtain a referral form from your primary doctor before seeing our doctors. Copayments are required before services are rendered (NO EXCEPTIONS)

REFERRING DOCTOR INFORMATION

Were you **referred** to this office by a doctor? If so, please provide the following information:

Referring Doctor's Name: _____ Phone: _____ Fax: _____

Address: _____

Please note: All HMO policy holders must fill in a referring doctor's information.

Would you like us to send information regarding your visits to another physician (other than the above-named doctor)?

Physician's Name: _____ Phone: _____ Fax: _____

Address: _____ Specialty: _____

I do not wish to have any of my medical information sent to any doctor.

Patient signature: _____ **Date:** _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Dr. Vinay Katukuri for services rendered by him I understand that I am financially responsible for any balance not covered by my insurance.

Initial: _____

AUTHORIZATION OF RELEASE OF INFORMATION

I hereby authorize Dr. Vinay Katukuri to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Initial: _____

CANCELLATION POLICY

As a courtesy, and to accommodate all our patients, we ask that you give 24 hours notice for cancellation or rescheduling of an appointment. A $25.00 (office visit) or $50.00 (procedure) fee will be charged for failure to comply with this request. This applies to all office visits and procedures.

Initial: _____

ADVANCE DIRECTIVE

Advance directives are legal documents that allow you o make informed decisions about end-of-life care. The directive gives you the option to let your family, friends, and health care professionals be aware of your personal decisions regarding your end-of-life care.

Do you have an advance directive? Yes / No

Initial: _____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to Advance Gastroenterology to use and disclosures of my health information and insurance/payment information which specifically identifies me, or which can reasonably be used to identify me for treatment, payment and health care operations in accordance with Advanced Gastroenterology. I understand that while this consent is voluntary, if I refuse to sign this consent, Advanced Gastroenterology can refuse to treat me.

I understand that I have the right to request that Advance Gastroenterology restrict how my health and insurance/payment information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that Advance Gastroenterology does not have to agree to such restrictions but that once such restrictions are agreed to, Advance Gastroenterology must adhere to such restrictions.

I understand that I may revoke this consent at any time by notifying Advance Gastroenterology in writing, but if I revoke my consent, such revocation will not affect any actions that Advance Gastroenterology took before receiving my revocation.

Patient/Representative Signature: _____ Date: _____

DESIGNATED REPRESENTATIVE

Please designate ONE representative to obtain medical information for you should you become unable to contact the office. The law **ONLY** permits medical information to be given to the person you designates. Please notify all other relatives and friends that no medical information will be given to any other person.

I designate: _____ D.O.B. _____

I designate: _____ D.O.B. _____

Patient/Representative Signature: _____ Date: _____

HIPAA – CONSENT FORM FOR PATIENT

Acknowledgment of Receipt of Notice of Notice of Privacy Policies and consent for Disclosure for Treatment, Payment and Operations.

ACKNOWLEDGEMENT AND CONSENT

By signing below, I hereby acknowledge that (if requested) I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by this office. I have also been advised of how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of Patient or Personal Representative:

_____

Print Name of Patient

_____

Print Name of Personal Representative (if applicable) & description of legal authority

_____

Date

_____

What is the reason of your appointment? _____

_____

MEDICAL HISTORY

List any current medications.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List any medical conditions that you have been diagnosed with either in the past or currently.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List any previous surgeries.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Any family history with gastrointestinal cancer? Yes / No **If yes, who and what type of cancer:**

_____ _____ _____
_____ _____ _____

Allergies to medication or other?

_____ _____ _____
_____ _____ _____

Are you a?
- ☐ Current smoker
- ☐ Former smoker
- ☐ Nonsmoker

Did you have a drink containing.
alcohol in the past year?
YES / NO

Have you ever had a Colonoscopy?
- ☐ Yes
- ☐ No

If yes, please specify year of last exam _____

Have you ever had an Endoscopy?
- ☐ Yes
- ☐ No

If yes, please specify year of last exam _____

Have you had any recent labs?
Yes / No
If yes, When? _____
Where? _____

Any recent Ultrasound, Ct Scan or MRI?
Yes / No
If yes, When? _____
Where? _____