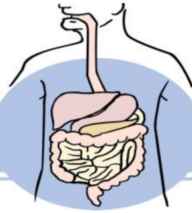

Digestive and Liver Center of Florida

Colorectal Surgery Department

Patient Last Name_________________________________ First Name ___________________________ MI ____________

Mailing Address ____ City __________________________ State ______

Zip ____________ Social Security # ________________________________ DOB _______________ Age _______

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Separated ☐ Divorced

Spouse or Partner's Name ____

Sex ☐ Male ☐ Female **Are you** ☐ Visually Impaired ☐ Hearing Impaired

Primary Language _______________________ **Ethnicity** _______________________ **Race** _____________________

Please furnish your email so that we may contact you about appointments and other health communications including marketing newsletters ______________________________@____________________.

Preferred Pharmacy _________________________ Address ______________________ Phone ___________________

Primary Care Physician ____ Phone __________________________

Who referred you to our office? ____ Phone _________________________

Preferred method of Contact: Home Phone ____________________________ Work Phone _______________________

Cell Phone __________________________________

The following information will assist us in communicating with you about your care while protecting your confidentiality. When we return calls and an answering machine picks up, we do not leave a message if the name of the telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. Please note that based on our Notice of Privacy Practices appointment reminders will be made through our Digestive and Liver Center automated system.

May we speak with any other person other than you regarding medical information? Yes ___________ No ___________

If yes please list name and phone numbers below

____________________________________ Phone ___________________ Relationship to patient ___________________

____________________________________ Phone ___________________ Relationship to patient ___________________

May we speak with any other person other than you regarding insurance or financial information? Yes_______ No______

____________________________________ Phone ___________________ Relationship to patient___________________

____________________________________ Phone ___________________ Relationship to patient___________________

Emergency Contact _______________________________ Phone# __________________ Relationship _______________

Office Use Only
Account # __________________ Forms Reviewed _________________ Forms Scanned ________________

Digestive and Liver Center of Florida Colorectal Division

Today's Date: ______________________

Last Name: __________________________ First Name: ________________________ Middle Name: _______________

Date of Birth: __________________________

PRIMARY INSURANCE INFORMATION

Please provide a copy of your insurance cards to the front desk staff.

CONSENT FOR TREATMENT

You agree to permit your protected health information to be used and disclosed for purposes of treatment, payment, and health care operations. For more details about these uses and disclosures, please see our Privacy Notice. We reserve the right to change our privacy policies described in the Privacy Notice. You may call us to receive an updated Notice. You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree with this request, but if we do, we are bound by it. You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use or disclosure of your information.

I have read and agree to the information above.

____

Patient or Responsible Party Signature   Date

____

Relationship to Patient   Reason why patient cannot Sign

____

Print Name Primary   Phone Number

Office Use Only
Insurance information added and verified ____________ Insurance card scanned into system ________________

Digestive and Liver Center of Florida Colorectal Division

Today's Date: ________________________

Last Name ________________________________ First Name _______________________________ Middle Name ______________________

Date of Birth: _____________________________

REASON FOR VISIT: Please describe the problem which prompted your visit ____

____

Date of last Colonoscopy? _______________________________ If yes, where was it performed: ______________________________________

MEDICATIONS: Please list all prescribed OR over-the-counter medications/supplements (including Aspirin, Advil, Exedrin, vitamins and herbal compounds) prescribed or taken recently. Please include the dose and frequency for each item listed.

____

____

Do you have any allergies? If yes, please list: ____

Allergies to Medications: ____

Any problems with iodine or intravenous contrast (dye)? [ ] YES [ ] NO Novocain? [ ] YES NO [ ]

Have you ever experienced any problems with anesthesia? [ ] YES [ ] NO Explanation:______________________________

MEDICAL HISTORY:

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
GASTROINTESTINAL			**RESPIRATORY**			**SKIN**		
Colon Cancer			Asthma			Squamous cell cancer		
Rectal Cancer			Pneumonia			Basal cell cancer		
Anal Cancer			Bronchitis			Melanoma		
Irritable Bowel			Chronic Cough			**OPHTHALMIC**		
Crohn's Disease			Hoarseness			Cataracts		
Ulcerative Colitis			COPD			Glaucoma		
Acid Reflux			**GENITOURINARY**			Blindness		
Abscess (pus collection)			Kidney Disease			**EAR, NOSE OR THROAT**		
Pilonidal cyst			Frequent Urine Infections			Loose Teeth		
polyps			**ENDOCRINE/ METABOLIC**			Nosebleed		
HEPATIC/PANCREATIC			Diabetes			Deafness		
Liver Disease			Thyroid Disorder			**PSYCHOSOCIAL**		
Hepatitis			**NEUROLOGIC**			Alcoholism		
Pancreatitis			Seizures			Substance Abuse		
CARDIAC			Stroke			Depression		
High Blood Pressure			Migraines			Anxiety Disorder		
Low Blood Pressure			**MUSCULOSKELETAL**			**BREAST**		
Heart Attack			Muscle Disease			Fibroadenoma		
Elevated Cholesterol			Arthritis			Breast Cancer		
			Neck Pain					
			Back Pain					
			Blood Disorder					

Any other medical problems not mentioned above? ____

SURGICAL HISTORY: Please list any surgeries that you had in the past.

____

Digestive and Liver Center of Florida Colorectal Division

Last Name ________________________________ First Name ________________________________ Middle Name ______________________

Date of Birth: _____________________________

FAMILY HISTORY: Please list ANY medical family history (siblings, parents, grandparents, aunts and uncles)? Has anyone in your family (blood relatives) ever been diagnosed with:

	NO	YES		NO	YES
Colon Cancer			Ulcerative Colitis		
Rectal Cancer			Crohn's Disease		
Anal Cancer			Colonic Polyps		
Ovarian Cancer			Lynch Syndrome		
Breast Cancer			Pancreatic Cancer		

SOCIAL HISTORY:

Do you currently use tobacco products? Yes______ No______ Have you ever smoked? Yes______ No______

Do you currently use recreational/illicit drugs? Yes______ No______

How many alcoholic drinks you have: a week __________? A month ____________?

What is your occupation? ____

How do you identify yourself? Heterosexual__________ Homosexual__________ Bisexual__________ Transgender__________

REVIEW OF SYSTEMS: Have you experienced any of the following symptoms? If yes, check the ones that apply.

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
GENERAL			***ENTIRESPIRATORY***			***DERMATOLOGIC***		
Fever or night sweats			Trouble breathing			Rash		
Chills			Cough			Wounds		
Fatigue			Wheezing			Itching		
HEMATOLOGICAL			Hearing Loss					
Easy bleeding			Ringing in ears			***MUSCULOSKELETAL***		
Easy bruising			Nose Bleeds			Muscle Pain		
Anemia			Sore throat			Joint Pain		
Past transfusions			Voice changes			Joint swelling		
Swollen glands						Joint stiffness		
			CARDIAC			Leg cramps		
GASTROINTESTINAL			Shortness of breath when walking					
Poor appetite			Swelling of ankles			***NEUROLOGIC***		
Weight Loss			Chest Pain			Numbness or tingling		
Trouble Swallowing			Irregular Heartbeat			Weakness		
Heartburn			Chest Palpitations			Headaches/migraines		
Blood in your stool						Lightheaded		
Diarrhea			***GENITOURINARY***			Dizziness		
Constipation			Pain with urination			Seizures		
Abdominal Pain			Blood in urine					
Change in bowel movements			Inability to hold urine			***ENDOCRINE***		
Nausea						Hot or cold intolerant		
Vomiting			***PSYCHIATRIC***			Excessive thirst		
Rectal Bleeding			Memory loss or confusion			Hair loss		
Rectal Pain			Depression			Excessive sweating		
Rectal Itching			Anxiety					
Inability to hold stool			Tension or stress			***HEENT***		
Bloating or belching			Sleep disturbances			Head Trauma		
						New changes in vision		
						Eye redness		
						Ear pain		
						Ear discharge		
						Runny nose		
						Sore throat		

Digestive and Liver Center of Florida Colorectal Division

BOWEL SYMPTOM QUESTIONNAIRE

Name: ____ Date of Birth: ________________________________

Doctor: ____ Phone #: ____________________________________

Do you have bowel movements every day? ________. How many times a day? ___________. If you don't have a bowel movement every day, how many times a week? __________.

How are your bowel movements? Hard_______ Soft_______ Loose_______

Which symptoms best describe you? Check all that apply.

- ☐ Accidental loss or leakage of stool—sometimes unable to make it to the bathroom in time.
- ☐ Bowel accidents while unaware - no warning and/or while asleep.
- ☐ Frequent, loose, watery stools.
- ☐ Sudden or strong urge to go to the bathroom.
- ☐ Bowel accidents when passing gas.
- ☐ Strain for most of your bowel movements.
- ☐ Have lumpy or hard stools most of the time.
- ☐ Have sensation of incomplete evacuation.
- ☐ Have to use digital maneuvers in order to have a bowel movement.
- ☐ Have sensation of blockage or obstruction when you have a bowel movement.
- ☐ Have abdominal pain that resolves after having a bowel movement.
- ☐ No bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? ____

Approximately how many bowel incidents do you have per week? ____

Have you tried medications to help your symptoms?

	Yes		No

What medications have you tried? ____

FOR WOMEN ONLY:

# of pregnancies ___________ # of vaginal deliveries _____________

For the following questions, please answer yes or no.

Are you pregnant or breast feeding? ______________

Have you had a hysterectomy (removal of your uterus)? ________________

If you still have your uterus, was your last PAP smear normal? _______________

Do you still have both of your ovaries? _________________

Have you ever been told by your doctor that you have endometriosis? ______________

Signature: ____ Date: _______________________________

If the person completing this form is not the patient, please give name and relationship: ____

FINANCIAL AGREEMENT

Patients are responsible for any and all charges incurred resulting from treatment provided at Digestive and Liver Center of Florida. As a service to our patients, Digestive and Liver Center of Florida will file claims with most insurance carriers directly; however, you are primarily responsible in full for your balance and for all services rendered. Please be aware that the contractual agreement is between yourself and your insurance company, not the physician's office. It is your responsibility to call and verify your coverage, know your benefits and know if authorization is required prior to scheduling your appointment. In cases where we participate with your insurance as a preferred provider; deductibles, co-pays, and co-insurance payments are due in full and expected at the time of service. All quotes given by our business office for services, co-pays, co-insurance, etc. are estimates only. We accept money orders, personal checks, Visa, MasterCard, and Discover as payment options.

COLLECTION PROCEDURE: If your account does not clear in a timely manner and you have not supplied requested information to our billing office, your account will be turned over to a third party collection agency. To prevent this from happening, we ask that you keep in communication and comply with our billing office in regards to your account. If any balance is due after your insurance has processed, you will receive three statements. After the third statement your account will be turned over to a collection agency if arrangements are not made.

Procedures: Digestive and Liver center of Florida will contact your insurance company prior to any procedure being performed and obtain an estimate of your out of pocket cost. All deductibles, co-insurance and out of pocket will be collected prior to the service being performed. These are estimates only. If there are any balances after insurance process the claim will be billed to you. All credits will be returned within 4 weeks. Please be aware that when a procedure is performed you will not only receive a billing from Digestive and Liver Center of Florida but also from the ambulatory surgery center, LifeLinc anesthesia and from Pathology Associates. These separate statements conform to current standards of billing practices within the healthcare industry. Any claim over 90 days, processed by the insurance company and left unpaid will be turned over to the collection department.

It is your responsibility to update **Digestive and Liver Center of Florida** with any insurance changes prior to a scheduled appointment.

LABS: Lab work will be sent to our normal reference lab unless you are covered by an insurance plan that requires us to send your lab work to a specific reference lab. Some insurance plans do not require the use of a specific lab, but your out of pocket expense may be higher if we send your lab work to our normal reference lab. Unfortunately, it is not possible for us to know the details of every insurance plan. In fact, two patients with the same insurance coverage may not have the same benefits due to employer determined benefit levels.
It is your responsibility to let us know if you have a lab preference based on your insurance plan.

You may receive a separate bill from the reference lab performing the testing for any lab. Please call the number on your lab statement should you have any questions or need to make payment arrangements

All billing questions are to be directed to the billing department.

We will process patient charges as follows:

SELF PAY/NO INSURANCE: Payment is due in full at the time services are rendered.

MEDICARE: Digestive and Liver Center of Florida is a participating provider of Medicare. All Medicare supplemental insurances will be filed. Patients are responsible for their deductibles, co-pays, and co-insurance payments which are due in full at the time services are rendered.

COMMERCIAL INSURANCE: As a courtesy to you, we will file your primary and secondary insurance. It is your responsibility to verify your benefits if authorization is required for our participation with your insurance company, prior to your appointment. You must provide correct insurance billing information, along with a copy of your insurance card(s) at your appointment. Patients are responsible for the full balance on their accounts.

HMO/PPO PLANS: As a courtesy to you, we will file your insurance. It is your responsibility to verify your benefits and our participation with your insurance company, prior your appointment.

OUT OF NETWORK and No Insurance: Digestive and Liver Center of Florida offers an out of network /no insurance discount for patients that choose to receive treatment at our facility.

- **NO SHOW POLICY for Office Visits:** Digestive and Liver Center of Florida requires a 24-hour cancellation notice for all scheduled appointments not kept or the patient may be charged a $25.00 fee for the missed appointment. Insurance does not cover this charge.
- **NO SHOW POLICY for Procedures:** Digestive and Liver Center of Florida requires a 24-hour cancellation notice for all scheduled appointments not kept or the patient may be charged a $100.00 fee for the missed appointment. Insurance does not cover this charge.

RETURNED CHECK POLICY: You will be charged a $30.00 fee on all returned checks regardless of the reason.

I understand that by signing this Financial Agreement form, I agree to all the above (regardless of insurance status). I am ultimately responsible in full for all charges and balances on my account(s) for all services rendered by Digestive and Liver Center of Florida. A copy of this agreement will be provided upon request.

Patient Name (print): ______________________________ **Date:** ______________

Patient Signature: ____

PATIENT PORTAL CONSENT

Digestive and Liver Center of Florida offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to log into the portal site. Because the connection channel between your computer and the website uses secure sockets layer (SSL) technology, you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure, depend on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your coned email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure message from, a website, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly to the website and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal that appears on the login screen. I understand the risks associated with online communications between my physician and me, and consent to the conditions outline herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the login screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

____________________________________	____________________________________
Patient Name (Print)	Patient Signature
____________________________________	____________________________________
Date of Authorization	Date of Birth

Email Address (PLEASE PRINT): ____

Digestive and Liver Center of Florida

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment.
- a means of communication among the many health professionals who contribute to my care.
- a source of information for applying my diagnosis and surgical information to my bill.
- a mean by which a third-party payer can verify that services billed were actually provided.
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a Notice of Privacy Practices that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

PATIENT NAME: ____

(PLEASE PRINT)

______________________________ ______________________________

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE WITNESS

DATE: ______________________

Privacy Notice Date: 06/15/2015

PELVIC EXAMINATIONS CONSENT FORM

Patients Name: ____

Date of Birth: ______________________________________

CONSENT: I, the above listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examinations being performed by my physician or other health care practitioner, any medical student or any student receiving training as a health care practitioner. I understand that this consent form will be valid and remain in effect as long as I receive medical care at Digestive and Liver Center of Florida.

- **NATURE OF PELVIC EXAMINATIONS:**

For the purposes of this Consent Form, a "pelvic examination" on a female means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation (i.e. Anoscopy).

For purposes of the Consent Form, a "pelvic examination" on a male means examination of the rectum, prostate, and external tissue or organs, including the penis or scrotum using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation (i.e. Anoscopy).

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient's Signature	Date
Legally Authorized Person Signature	Relationship to Patient
Legally Authorized Person Printed Name	Date
Witness Signature	
Witness Printed Name	Date

Consent for Non-Face-to-face "Virtual" Visits

Patients Name: ____ Date of Birth: __________________________________

I, ___________________________________ hereby voluntarily consent to receive "virtual" care. Examples of the virtual services offered here are:

Virtual check-ins: You and your treating provider may have a brief phone call to determine whether or not an in-person visit or other appropriate treatment is needed.

Telehealth visits: You and your treating provider can use real-time interactive audio and/or video communication that permits real time communication—like Doximity, FaceTime, Skype, of WhatsApp—to conduct a visit while you are home.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Digestive and Liver Center of Florida.

"Virtual Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communications. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the Provider. _______ (initials)

I understand that my voice and image may be recorded in order to assist in my treatment and I consent to any such audio and video recording. _______ (initials)

I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand that there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation. _______ (initials)

I understand that I may be disconnected before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care. _______ (initials)

I understand that standard deductible and coinsurance amounts apply to these "Virtual Visits" and I consent to Virtual Treatment. _______ (initials)

This form has been explained to me and I fully understand this *Consent for* **Non-Face-to-Face "Virtual" Visits** and agree to its contents.

Signature of Patient or Person Authorized to consent for Patient: ____

Name: ____ Date: _____________________________