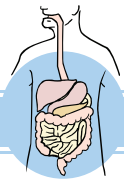

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Patient Last Name_____ First Name _____MI_____

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 practice newsletters_____Yes_____No

Marketing Information_____Yes_____No

_____@_____.

Preferred Pharmacy _____ Address_____ Phone_____

Primary Care Physician _____ Phone _____

Who referred you to our office? _____Phone _____

Other physicians involved in care_____

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_____

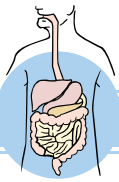
_____ Phone _____ Relationship to patient_____

_____ Phone _____ Relationship to patient_____

Emergency Contact _____ Phone# _____ Relationship _____

Office Use Only

Account # _____Forms Reviewed _____ Forms Scanned _____



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PRIMARY INSURANCE INFORMATION

Name of Primary Insurance_____

Address _____

Insurance ID#: _____ Group # _____

Subscriber Name (whose job provides plan?): _____

Subscriber's Date of Birth: _____ Sex: M or F

Subscriber's Social Security #: _____

Do you have a secondary insurance plan? Yes No

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance_____

Address _____

Insurance ID#: _____ Group # _____

Subscriber Name (whose job provides plan?): _____

Subscriber's Date of Birth: _____ Sex: M or F

Subscriber's Social Security #: _____

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

_____ _____

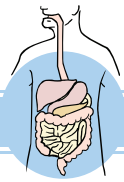
Relationship to Patient Reason why patient cannot Sign

_____ _____

Print Name Primary Phone Number

Office Use Only

Insurance information added and verified _____ Insurance card scanned into system_____



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TO OUR PATIENTS: Welcome to our practice. Please take your time to complete this form. If you have any questions, please ask for assistance. Thank you.

DIGESTIVE AND LIVER CENTER OF FLORIDA

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, please give date: _____

Please list any lab tests, procedures or X-ray/radiology studies performed (e.g. by another physician or ER visit), that may relate to your current problem:_____

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

_____

_____

_____

_____

Allergies to Medications: _____

Other Allergies:_____

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

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

SURGICAL HISTORY: Please list ANY operations/surgical procedures performed in the past? LIST YEAR &TYPE OF SURGERY

_____

HOSPITALIZATIONS: Please list any medical illnesses that required hospitalization (other than for surgery or childbirth)

_____

Do you currently use tobacco products? _____How many years have use used tobacco products? _____

If so what type _____and how much per day_____ per week _____ per month_____

Have you previously used tobacco products in the past and stopped _____

If so what type _____and when did you stop? _____

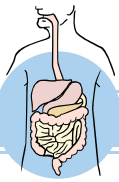
Do you currently use recreational/illicit drugs? _____

If so what type _____ and how much per day _____per week _____per Month _____

Have you previously used recreational/illicit drugs and stopped? _____

If so what type_____ and when did you stop? _____

Alcohol – How many drinks per day _____ Per Week _____ Per Month_____



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Have you ever been diagnosed with any of the following? If yes please check any that applies.

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
GASTROINTESTINAL			**RESPIRATORY**			**SKIN**		
Diarrhea			Asthma			Rash		
Constipation			Pneumonia			Bruises		
Rectal Bleeding			Bronchitis			**OPHTHALMIC**		
Change In Bowel Movements			Chronic Cough			Cataracts		
Weight Loss			Hoarseness			Glaucoma		
Polyps			Tracheostomy			Blindness		
Irritable Bowel			**GENITOURINARY**			**EAR, NOSE OR THROAT**		
Crohn's Disease			Kidney Disease			Loose Teeth		
Ulcerative Colitis			Frequent Urine Infections			Nosebleed		
Trouble Swallowing			**ENDOCRINE/ METABOLIC**			Deafness		
Nausea/Vomiting			Diabetes			**PSYCHOSOCIAL**		
Heartburn			Thyroid Disorder			Alcoholism		
Abdominal Pain			**NEUROLOGIC**			Substance Abuse		
HEPATIC			Seizures			Depression		
Liver Disease			Weakness			Anxiety Disorder		
Hepatitis			Migraines			**BREAST**		
Pancreatitis			Previous Stroke			Lumps		
CARDIAC			**MUSCULOSKELETAL**			Cancer		
High Blood Pressure			Muscle Disease					
Low Blood Pressure			Arthritis					
Irregular Heartbeat			Neck Pain					
Chest Pain			Back Pain					
			Blood Disorder					

Please list any symptom or Disease not listed above: _____

Please give additional details on any boxes checked yes above: _____

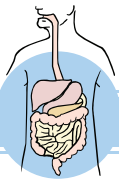
_____

_____

_____

Signature: _____ **Date:** _____

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



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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 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 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 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 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, P.A. A copy of this agreement will be provided upon request.

Patient Name (print):_____**Date:**_____

Patient Signature:_____

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PATIENT PORTAL CONSENT

Digestive and Liver Center of Florida, PA 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 4commünications, 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 correct 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): _____

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BOWEL SYMPTOM QUESTIONNAIRE

Name: _____ Date of Birth: _____

Doctor: _____ Phone #: _____

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.
- ❑ 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

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Behavior modifications tried? _____

(e.g., lifestyle changes, fiber, diet changes, physic& therapy)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Very Frustrated***

Are you interested in learning more about additional treatment alternatives to bowel medications?

❑ Yes ❑ No

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ACKNOWLEDGEMENT OF RECEIPT 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 or Legal Representative Witness

Date: _____

Privacy Notice Date: 06/15/2015