PATIENT INFORMATION

483 N Semoran Blvd
Suite #101
Winter Park, FL 32792-3800

FLORIDA GASTROENTEROLOGY/GUARDIAN HEALTH SOLUTIONS LLC

Date:_____

SSN: _____Sex: *Male/Female* Marital Status: *Single/Married/Divorced/Widowed*
Date of Birth: _____Age: _____
First Name: _____Middle: _____Last: _____
Home phone: _____Cell phone: _____Work phone: _____
Address:_____City:_____State:_____Zip:_____
Current Employment Status: *Full-time/Part-time/Retired/Unemployed*
Employer:_____Address: _____City:_____Zip:____

Name of Doctor/Person who referred you to Dr. Bajaj:_____

Name of person to notify in case of emergency:_____Phone:_____
Relationship to contact: _____

INSURANCE INFORMATION

WE WILL NEED YOUR CURRENT INSURANCE ARD AND DRIVERS LICENSE PLEASE GIVE IT TO THE RECEPTIONIST TO MAKE COPIES

Do you have Medicare: ☐Y ☐ N #_____Medicaid: ☐Y ☐ N #_____

PRIMARY INSURANCE

Company:_____Address:_____
Member ID#:_____Group #:_____
Subscriber: ☐ Self ☐ Spouse ☐ Guardian
Subscriber's Name: _____DOB:_____
Address: _____

SECONDARY INSURANCE

Company:_____Address:_____
Member ID#:_____Group #:_____
Subscriber: ☐ Self ☐ Spouse ☐ Guardian
Subscriber's Name: _____DOB:_____
Address: _____

I understand and agree, I will be responsible for the payment of the charges incurred on behalf of myself or family member.

PATIENT METHOD OF DISCOLSURES-The HIPPA Privacy Rule gives the individual the right to request their confidential communications be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

☐ OK to leave messages with detail information on HOME/CELL/WORK Phone
☐ Home Telephone: _____☐Cell phone_____☐Work phone_____
☐ OK to e-mail_____
☐OK to mail to my home address ☐ OK to leave message with call back number only
Person/Persons who are allowed to obtain your Health Information:_____
_____

ASSIGNMENT OF BENEFITS/MEDICAL REALEASE

I request that payment of authorized benefits be made for any services furnished to me by Florida Gastroenterology/Guardian Health Solutions LLC of its legal subsidiaries, affiliates, successor and assigns. If my current policy prohibits direct payment to the provider, I hereby acknowledge that I am responsible for submitting payments received to the provider for services furnished to me by the provider. I also understand that I am financially responsible for services not covered by benefits. I authorize any holder of medical or other information about me to release information needed to any person, accreting or certifying/professional organizations company and/or agency which is or may be liable for any portion of the payment of the changes for such services, ore performing audits. In addition, I authorize Florida Gastroenterology/Guardian Health Solution LLC to request and obtain any necessary medical reports necessary for comparison purposes associated with my treatment.
I acknowledge that I have received Florida Gastroenterology/Guardian Health Solutions LLC Notice of Privacy Acts.

Patient Signature:_____Date:_____

FLORIDA GASTROENTEROLOGY, P.A.
PATIENT MEDICATION FORM

Patient Name: _____ DOB : _____ Today's Date: _____

Pharmacy (preferred): _____ Pharmacy phone # : _____

Please complete the following form in detail prior to your appointment and bring this form with you. Be sure t include ALL MEDICATIONS INCLUDING VITAMINS, HERBS AND OVER THE COUNTER DRUGS (ASPIRIN ETC AS WELL AS YOUR PRESCRIPTION DRUGS AND THE AMOUNT AND FREQUENCY YOU TAKE THEM.

If you are unable to complete this form, please bring all your medications to your appointment and someone wi assist you to fill out this form.

	NAME OF MEDICATION	DOSAGES/STRENGTH	DIRECTIONS/HOW OFTEN USED
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

ALLERGIES

Drug	Reaction	Drug	Reaction

FLORIDA GASTROENTEROLOGY, P.A.

PLEASE DESCRIBE THE REASON YOU ARE SEEING THE PHYSICIAN TODAY: _____

_____

Past Medical History - Patient Name: _____ Date: _____

Please check if you have ever had problems with the following:

- ☐ Heart Disease
- ☐ Angina
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker/Defibrillator
- ☐ Irregular Heart Beat
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Lungs/Breathing Difficulties
- ☐ Pulmonary Embolism
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Clots/Bleeding Problems
- ☐ HIV
- ☐ Hepatitis
- ☐ Varicose Veins
- ☐ Back Problems
- ☐ Parkinson's
- ☐ Arthritis
- ☐ Paralysis
- ☐ Fainting
- ☐ Headaches
- ☐ Seizure
- ☐ Stroke or mini-stroke
- ☐ Dizziness/Falling
- ☐ Glaucoma [R] [L]
- ☐ Cataracts [R] [L]
- ☐ HOH
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Heartburn/Indigestion
- ☐ GERD/ Hiatal Hernia
- ☐ Gallstones
- ☐ Liver Problems
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Prostate Problems
- ☐ Pancreatitis
- ☐ Depression
- ☐ Anxiety
- ☐ Cancer
  Where? _____
- ☐ Recreational Drug Use

Other: _____

Past Surgical History

Please check all previous surgeries that you have had:

- ☐ Abdominal Surgery
- ☐ Appendectomy
- ☐ Colon Surgery
- ☐ Gall Bladder Surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia [R] [L]
- ☐ Hiatal Hernia Repair
- ☐ Breast/Mastectomy [R] [L]
- ☐ Angioplasty/Stent Placement
- ☐ Heart Surgery
- ☐ Pacemaker
- ☐ Arm/Hand/Foot [R] [L]
- ☐ Neck/Back Surger
- ☐ Hip Surgery [R] [L]
- ☐ Knee Surgery [R] [L]
- ☐ Shoulder Surgery [R] [L]
- ☐ Cesarean
- ☐ D&C
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Eye / Cataract [R] [L]
- ☐ Tonsillectomy
- ☐ Colonoscopy
- ☐ Endoscopy
- ☐ Flex Sig
- ☐ Barium Enema

Year of Procedure _____

ALLERGIES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Other: _____

List all Medications - Prescription and Non-Prescription drugs including Vitamins/Supplements and Herbal remedies

_____

_____

OFFICE USE ONLY Patient Signature _____ **Date** _____

ASA STATUS Airway: MP I II III IV Neck: FROM LROM _____ H/O Difficult Intubation Y N Teeth _____

Respiratory: LCTA: Y N _____ Cardiac: S1 S11 S111 RR IR Murmur Y N _____

1 2 3 4 E NPO Y N _____ Other Significant Exam Findings: _____

FAMILY HX

1) ☐ EPLEPSY	6) ☐ ARTHRITIS	11) ☐ CELIAC DIS	16) ☐ COLITIS
2) ☐ STROKE	7) ☐ KIDNEY DIS	12) ☐ CANCER	17) ☐ CROHNS
3) ☐ MENTAL DIS	8) ☐ ANEMIA	13) ☐ COL CANCER	18) ☐ PANR
4) ☐ DIABETES	9) ☐ HEART DIS	14) ☐ POLYPS	19) ☐ LIVER DIS
5) ☐ ASTHMA	10) ☐ HYPERT	15) ☐ PUD	

Pre Anesthesia Orders:

Consent completed

IV Saline at KVO Rrate

Post Anesthesia Orders:

Monitor patient with Pulse Oximeter. If O2 saturation drops below 92% place on supplemental O2

VS Q 15 minutes if stable

PO Fluids as tolerated

PLAN: ☐ General anesthesia ☐ Subarachnoid Block ☐ Epidural ☐ Regional ☐ Monitored Anesthesia Care ☐ Risks / procedures / benefits / options of anesthesia discussed with patient or patients representative who understands and accepts. All questions answered.

Signature _____ Date _____

FLORIDA GASTROENTEROLOGY, P.A.
FINANCIAL POLICY

The following sets forth the general financial policy of Florida Gastroenterology, P.A. Please review this information and sign where indicated.

The patient is responsible to provide the office staff of Florida Gastroenterology, P.A. with current, accurate billing/ insurance information at the time of check in and to notify Florida Gastroenterology, P.A. of any changes in this information. Any patient with insurance coverage that is a Medicare replacement plan and have a secondary insurance plan; such as Medicaid, need to be aware that the secondary insurance will not pay for an portion of the bill and the patient will be responsible to pay for any remaining balances after the Medicare replacement plan pays.

The specialist co-pay (which can be different than my Primary Care co-pay) is to be paid prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that Florida Gastroenterology, P.A. also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

There will be an insufficient funds fee of $25 charged to my account if an insufficient funds check is given for payment, I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

There is a $50 fee if I do not give two business days advance notice when cancelling or rescheduling for any radiology or endoscopy procedures.

I understand that Florida Gastroenterology, P.A. will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective procedures that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective procedure. I further understand that the FEE I AM QUOTED IS AN ESTIMATE based on the anticipated procedure to be performed and the current information provided to Florida Gastroenterology, P.A. by my insurance carrier.

I understand that I will be billed for any amounts due to me (co-payments/coinsurance amounts/deductible amounts) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment after the third "Final Notice" statement being mailed that my account will be sent to an outside collection agency. I also understand that I will be responsible for any collection, interest or attorney's fee's associated with the collection efforts.

I understand that the staff of Florida Gastroenterology, P.A. may contact me at any phone number that is provided to discuss financial responsibility, unless I submit a written request to restrict certain phone numbers where I can be contacted.

I understand that Florida Gastroenterology, P.A. will obtain the necessary authorizations prior to rendering treatment. I further understand that prior authorization is not guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

My signature below confirms that I have read and understand these financial policies and my financial obligation as pertains to the providers of Florida Gastroenterology, P.A.

PRINT-Patient Name

Enter Today's Date

Patient Signature or Legal Guardian Signature

Relationship to Patient and Account #

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name: FL Gastroenterology P.A. Phone: (407)895-9500

Address: 483 N Semoran Blvd Ste 101 Winter Park FL 32792 Fax: (321)274-0266

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the earlier of: my death or the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

X _____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004

"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Withdrawal": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. This authorization is automatically revoked when you die. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: *This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.*

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPAA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g ("FERPA"); 34 CFR parts 99 and 300; 42 CFR §59.11 (Family Planning); Florida Statute 408.051(4) ("Universal Patient Authorization Form"); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes §456.057(7)(a), §395.3025(4), §394.4615(2)(a), §381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).