

PATIENT HISTORY FORM

| Allergies | | Reaction | |
|---------------------------------------|---------------|--|---------------|
| | | | |
| | | | |
| | | | |
| List Prior Surgeries | | Year/ Date | |
| | | | |
| | | | |
| | | | |
| Prior GI Procedures | | Year/ Date | |
| Colonoscopy | | | |
| Upper Endoscopy / EGD | | | |
| Endoscopic Ultrasound | | | |
| ERCP | | | |
| Family History: | Relationship | Onset Age/Died of Age | |
| Colon cancer | | | |
| | | | |
| Colon polyps | | | |
| | | | |
| Social History: | | | |
| Occupation: | | | |
| Tobacco Use | Yes No Former | Alcohol Use | Yes No Former |
| If yes: # packs per day: | | #drinks per day: | |
| For how long (# of years) | | For how long (# of years) | |
| G.I. Symptoms - Circle all that apply | | Other Symptoms - Circle all that apply | |
| Heart Burn | | Weight loss | |
| Difficulty swallowing | | Fever/chills | |
| Abdominal pain | | Dry eyes | |
| Nausea/ Vomiting | | Difficulty hearing | |
| Blood in stool | | Chest pain | |
| Hemorrhoids | | Shortness of breath | |
| Change in bowel habits | | Bleeding Tendency | |
| Constipation | | Skin rashes | |
| Diarrhea | | Headaches | |
| Jaundice | | Difficulty urinating | |
| Dark Urine | | Muscle aches | |
| Pale stools | | Sleep disturbance | |
| Pharmacy Information: | | | |
| Name: | | | |
| Location: | | | |
| | | | |
| | | | |



**CONSENT FOR TREATMENT
COMMUNICATIONS CONSENT
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
AND
AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS**

1. CONSENT TO TREATMENT

I, the undersigned, acting on my behalf or as the legally authorized representative of _____ (PATIENT) hereby consent to examination, diagnostic testing and treatment by Florida Digestive Health Specialists, LLP, and its employees and agents (together, FDHS). I understand that the physical examination may include a medically appropriate examination of my pelvic area, and/or rectum and I consent to such examination. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment provided by FDHS.

2. RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical information, including protected health information, concerning my treatment to any third-party payor, including but not limited to health plans and insurers, Medicare, Medicaid, TRICARE and CHAMPVA for payment purposes.

Further, I authorize payment of any insurance or other benefits that may be made on my behalf by any party, including any health plan or insurer, Medicare, Medicaid and any other federal or state health care programs, directly to FDHS. I understand that this assignment of benefits does not relieve me of my obligation to pay FDHS for any charges not covered by this assignment or not paid by insurance or health care benefits.

I understand and agree, whether I sign as Agent or Patient, that I am responsible for and guarantee payment of any charges incurred for the services provided to PATIENT by FDHS. I further understand and agree that I will be responsible for payment of any deductible, co-payment or co- insurance amounts, or any charge that is not covered or paid by insurance, health care benefits or third-party payors.

I authorize FDHS to release PATIENT's medical information, including HIV testing and treatment information, to other parties (which may include providers, payors, business associates or other entities) for the purpose of treatment, payment or healthcare operations.

Signature of Patient or Patient's Legal Representative

Name of Patient's Legal Representative and relation to Patient

Date: _____



COMMUNICATIONS CONSENT

_____ (initial) I authorize Florida Digestive Health Specialists (FDHS) to leave telephone messages for PATIENT that may contain medical information at the following number(s):

_____ (initial) I authorize FDHS to contact PATIENT at the following email address:

_____ (initial) I authorize FDHS to share PATIENT medical information with

_____ (Name and Relationship)

3. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you are agreeing that you have received a copy of FDHS's Notice of Privacy Practices, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Signature of Patient or Patient's Legal Representative

Name of Patient's Legal Representative and relation to Patient

Date: _____

For Office Use Only:

I personally delivered the Notice of Privacy Practices to the above-named patient (or authorized representative of the patient). A written acknowledgement of receipt by the patient or representative was not obtained for the following reason(s):

[Signature of Office Staff Member]

[Date]

Name: _____



FLORIDA DIGESTIVE HEALTH SPECIALISTS, LLP
FINANCIAL POLICY

Our practice is dedicated to providing the best possible care for you and we want you to completely understand our Financial Policy.

1. Payment for all co-pays, deductibles and outstanding patient balances is due at the time of service. We accept cash, checks and most major credit cards. There will be a minimum charge of \$25.00 on all returned checks.
2. Please be advised that your insurance policy is basically a contract between you and your insurance company.

We are participating providers with many insurance companies and other health plans, and we will file a claim and accept assignment of benefits on these claims. Payment will be made by the insurance company directly to Florida Digestive Health Specialists, LLP (FDHS).

If we do not participate with your insurance company, you will be responsible for paying your charges at the time of service. We will, however, provide you with a superbill summary of your visit for you to submit to your insurance company and if such charges are covered by your insurance company then the insurance company will pay you directly.

3. Not all insurance companies cover all services. If your insurance company determines a service to be "non covered", you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.
4. If you provide incorrect or false information that results in a denial of claim(s), you will be responsible for any unpaid claims and/or all charges for services provided.
5. We will bill your insurance company for services that were provided to you in a hospital setting. If your insurance company does not pay, you are responsible for any balance due.
6. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, included but not limited to all reasonable collection fees and/or reasonable contingency fees added by a third party to the outstanding or referred balance.
7. If you cannot keep your appointment for any reason, we require 24 hours' notice for office visits. If you do not give us the required notice, your account will be charged a \$25.00 no-show fee. If you do not provide 24 hours' notice for an ultrasound appointment cancellation, your account will be charged a no-show fee of \$50.00. If you do not give 72 hours' notice that you are cancelling your procedure(s), you will be charged a \$75.00 no-show fee.
8. If the patient or responsible party fails to pay for services rendered in accordance with standard practices, then such nonpayment will result in the patient/undersigned's provider, and all providers of FDHS, terminating their provider relationship with the patient/undersigned, in accordance with applicable law. All outstanding balances for services rendered will be referred to a collection agency.

I have read and understand the FDHS Financial Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by FDHS from time to time.

Signature of Patient (or Responsible Party)

Date

Please Print Name of Patient

Please Print Name of Responsible Party (if different from patient)

Witness

Dear Patient,

We believe that patients and your caregivers should have easy access to your medical information, no matter where you receive care. That's why we're participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that you receive optimal care.

What is CommonWell?

A *free, secure service* offered by your doctor, so your health information can be available to you and your doctors regardless of where you've received care.

You simply need to enroll in the service with a driver's license and then confirm the other CommonWell network doctors you see. Don't worry if you don't have a government-issued picture ID, you can still register.

How do we use the health information we share through CommonWell?

- **Better coordinate your care across different doctors** — We'll provide and request to receive your information *where* and *when* it's needed for your healthcare provider to deliver the care you need as you move from doctor to doctor.
 - Only healthcare staff directly involved in your care will access your medical information shared through CommonWell.
- **Support better care decision-making** — With timely access to information from other healthcare providers you've seen, your doctors may be able to make better decisions about your health.
 - This information will only be used to help improve your care; and won't be shared without your permission or unless it's required by law.
- **Deliver care more promptly and efficiently** — With less time wasted on tracking down your test results and other health information, your healthcare providers can treat you more efficiently, and spend less time on paperwork and more time on your care.
 - We do need your help in confirming the other doctors or hospitals you've visited when you enroll in CommonWell.
- **Securely and confidentially** — Your Protected Health Information ("PHI") will always be confidential and used to inform the CommonWell participating healthcare providers. We won't use your PHI for discriminatory purposes of any kind or to deny medical treatment.
 - You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from CommonWell.

- Accept
- Decline

Patient Signature _____

CommonWell Health Alliance

The CommonWell services are provided by the CommonWell Health Alliance trade association. We are devoted to the notion that patient data should be safely, securely and immediately available to patients and doctors regardless of where care occurs to deliver better care. We are committed to fostering standards that make this possible, and in having health information technology companies build these capabilities into their systems. The end results: higher quality, more timely, more cost-effective care that delivers better health outcomes. Participating vendors are: Allscripts, athenahealth, Cerner, CPSI, Greenway, McKesson, and Sunquest.