ENDOSCOPY CENTER OF OCALA, INC.

GASTROENTEROLOGY ASSOCIATES

PATIENT INFORMATION RECORD

TODAY'S DATE: _____

Name Miss Mrs. Mr. _____ _____ _____ SS#_____-_____-_____
(Last) (First) (MI)

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip)

Telephone: Home:_____ Work:_____ Cell:_____

Date of Birth____/_____/_____ Sex:____F _____M Email:_____

Preferred Language: _____English _____Spanish _____Other

Ethnicity **(circle one)** Hispanic/Latino Non-Hispanic/Latino Unknown Patient Refused

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Race **(circle one)** American Indian/Alaskan Native Asian Black/African American Caucasian/White Unknown Native Hawaiian/Pacific Islander

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Marital Status **(circle one)** Single Married Widowed Divorced Legally Separated Life Partner

If married, spouse's name:_____

In the event of an **emergency**, please provide the name/telephone number of the person(s) we should call:

Name:_____ Telephone:_____

Name:_____ Telephone:_____

Referring Physician (Name/City/State)_____/_____/_____

Family Physician (Name/City/State)_____/_____/_____

Other (Name/Specialty/City/State)_____/_____/_____

INSURANCE INFORMATION

Do you have "traditional" Medicare insurance? _____Y _____N Medicare # _____

If "No", what is the name of your insurance carrier or Medicare replacement?_____
Insurance address:_____
Group #:_____ ID#_____
Subscriber name:_____ DOB:_____ SSN_____-_____-_____

Do you have a secondary Insurance? If so, Name:_____
Insurance address:_____
Group #:_____ ID#_____
Subscriber name:_____ DOB:_____ SSN_____-_____-_____

Does your insurance require pre-admission certifications? _____Y _____N
If "Yes" please provide us with the telephone number: (_____) _____

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in correct billing procedures, please answer the following questions:

(1.) Is your illness due to
- A. A work-related accident/condition? _____Yes _____No
- B. An automobile accident? _____Yes _____No
- C. The fault of another party? _____Yes _____No

(2.) Are you eligible for coverage under the Veterans' Administration? _____Yes _____No

(*3) Are you a student? _____Yes _____No
If "Yes", are you a Full-Time Student? _____Yes _____No

(*4) Are you employed? _____Yes _____No
If "Yes", employer's name:_____
Employer's address:_____

If "No", please provide date of retirement if applicable:_____

(5.) Is your spouse employed? _____Yes _____No
If "Yes", please provide us with your spouse's name:_____
Spouse's employer name:_____
Spouse's employer address:_____

If "No", please provide date of retirement if applicable:_____

*PLEASE READ CAREFULLY **In consideration for services rendered by Gastroenterology Associates/Endoscopy Center of Ocala, I hereby agree to release the information requested, as needed, by my insurance company and assign insurance benefits to Gastroenterology Associates/Endoscopy Center of Ocala. I further agree to be solely responsible for any balances my insurance carrier does not pay.**

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT.

SIGNATURE:_____ DATE:_____

RELATIONSHIP TO PATIENT:_____

I request that payment of authorized Medigap benefits be made on my behalf to Gastroenterology Associates / Endoscopy Center of Ocala, Inc., for any services rendered by Gastroenterology Associates / Endoscopy Center of Ocala, Inc.

SIGNATURE:_____

PROTECTING YOUR MEDICAL HEALTH INFORMATION: **It is your right to control access and disclosure of your health information. Please list the names of family members and/or friends with whom we may share your medical information and/or lab results. DUE TO PRIVACY LAWS, WE WILL NOT GIVE ANY INFORMATION TO ANYONE WHO IS NOT ON THIS LIST!**

NAME(S): _____

_____

NOTIFICATION OF TEST RESULTS: Please call our office if you have not been notified of a test result by 14 days of having the test performed.

YOUR SIGNATURE: _____

Name Date

Reason For Visit

Allergies

- ⬭ Patient has no known drug allergies
- ⬭ Latex
- ⬭ Other_____
- ⬭ Other_____
- ⬭ Other_____
- ⬭ Other_____
- ⬭ Other_____
- ⬭ Other_____

- ⬭ Patient has no known allergies
- Reaction: _____
- Reaction: _____
- Reaction: _____
- Reaction: _____
- Reaction: _____
- Reaction: _____
- Reaction: _____

Current Prescription Medications, Over-the-Counter, Vitamins & Supplements

⬭ **None**

Name	Dose	How Taken

Pharmacy – List preferred local

Name Address PH#

Immunizations

- ⬭ Flu Date Last Received: _____
- ⬭ Pneumonia Date Last Received: _____

- ⬭ Patient Declined Flu Shot
- ⬭ Patient Declined Pneumonia Shot

Name _____ Date _____

Previous Gastro Procedures ○ None

○ Colonoscopy	Date of Last _____	If polyps were found, how many #_____
○ EGD	Date of Last _____	Findings: _____
○ ERCP	Date of Last _____	Findings: _____
○ EUS	Date of Last _____	Findings: _____
○ Sigmoidoscopy	Date of Last _____	Findings: _____
○ Capsule Endoscopy	Date of Last _____	Findings: _____

Previous Surgical Procedures ○ None

○ Colon Resection	Date _____	
○ Hysterectomy	Date _____	
○ Gallbladder	Date _____	
○ Hernia Repair	Date _____	Type: _____
○ Appendectomy	Date _____	
○ C-Section	Date _____	
○ Gastric Bypass	Date _____	Type: _____
○ Spleen Removal	Date _____	
○ Organ Transplant	Date _____	Type: _____
○ Lung Surgery	Date _____	
○ Blood Transfusion	Date _____	
○ Pacemaker	Date _____	
○ Heart Bypass	Date _____	
○ Defibrillator	Date _____	
○ Cardiac Stents	Date _____	

** Please list any additional surgeries below

○ _____	Date _____
○ _____	Date _____
○ _____	Date _____
○ _____	Date _____
○ _____	Date _____
○ _____	Date _____

Diagnostic Studies/Tests – Done in the last year ○ None

○ CT of _____	When:_____
○ MRI of _____	When:_____
○ PET Scan	When:_____
○ Virtual Colonoscopy	When:_____
○ Other:_____	When:_____

Name _____ Date _____

Past or Present Medical Conditions ○ None

○ A. Fib When: _____	○ Colon Polyps When: _____	○ Hemorrhoids When: _____	○ Cancer: Type: _____ When: _____
○ Anemia When: _____	○ Diabetes Mellitus When: _____	○ Hepatitis When: _____	○ Cancer: Type: _____ When: _____
○ Anesthesia Difficulties When: _____	○ Dialysis When: _____	○ High Blood Pressure When: _____	
○ Asthma When: _____	○ Diverticulitis When: _____	○ Pancreatitis When: _____	○ Other: _____
○ Barrett's When: _____	○ Emphysema When: _____	○ Sleep Apnea When: _____	○ Other: _____
○ Bleeding Problems When: _____	○ Epilepsy When: _____	○ Stroke or TIA When: _____	○ Other: _____
○ Cirrhosis When: _____	○ Gallstones When: _____	○ Tuberculosis When: _____	○ Other: _____
○ Colitis When: _____	○ GI Bleeding When: _____	○ Ulcerative Colitis When: _____	○ Other: _____

Social History

Occupation/Current: _____ Former(If Retired): _____

Alcohol ○ None

Type	Quantity	Frequency
○ Beer		times / day
○ Wine	Glasses	times / day
○ Liquor	Shots	times / day

Tobacco

Smoking Status ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Former Smoker
○ Smoker, current status unknown ○ Unknown if ever smoked ○ Never Smoker

Type	Started	Quit	Quantity	Frequency
○ Cigarettes				cigarettes / day
○ Cigar				times / day
○ Pipe				times / day
○ Smokeless				times / day

Family Medical History

	Age at Diagnosis			Current Age
Mother		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Father		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Sister(s)		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Brother(s)		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Daughter(s)		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Son(s)		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	

Name Date

Review of Systems – Have you had any of the following symptoms within the *past 2 months*

Cardiovascular	Yes	No
Chest Pain	○	○

Constitutional	Yes	No
Significant or unexplained weight loss	○	○
Significant weight gain	○	○

ENMT	Yes	No
Difficulty Swallowing	○	○
Nose Bleeds	○	○

Endocrine	Yes	No
Heat Intolerance	○	○

Gastrointestinal	Yes	No
Jaundice, yellow eyes, and/or skin	○	○
Rectal Bleeding	○	○
Black tarry stools	○	○

Genitourinary	Yes	No
Blood in Urine	○	○

Hematologic/Lymphatic	Yes	No
Unusual or excessive bleeding tendency	○	○
Prolonged bleeding/abnormal clotting	○	○
Excessive, prolonged, or abnormal bleeding associated with **any** past surgical procedures	○	○

Skin	Yes	No
Allergies, particularly to latex or tape	○	○
Rashes	○	○

Neurological	Yes	No
Seizures	○	○

Respiratory	Yes	No
Trouble breathing/shortness of breath	○	○
Coughing up blood	○	○
Use of home oxygen	○	○

Patient account # / Name

GASTROENTEROLOGY ASSOCIATES
OCALA ENDOSCOPY A.S.C.
LAKE ENDOSCOPY CENTER

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the highest standard of treatment. A part of this process involves the financial aspect of your treatment; the following information outlines your responsibility in this area.

1. We participate with a number of insurance companies and health plans. You should check with our office to see if your insurance is one that we file. If we do file your insurance, you are still responsible for any deductible or co-pay amount. If we do not file, you will be asked to pay in full and we will provide you with the receipts you will need to obtain reimbursement from your insurance.

2. If we participate with your insurance, we will file your claims and will allow 45 days for payment by your insurance company. After 45 days, the balance becomes your responsibility. It is also the patient's responsibility to discover why the insurance has not paid. Please remember that insurance is a contact between you and the insurance carrier – we are not a party to that contact.

3. If we are not participating providers, the filing of insurance claims is a courtesy provided by our office. We will verify insurance for all scheduled procedures; however, verification of benefits is not a guarantee of payment. In addition, the filing of a claim does not imply that we will accept the allowance paid by the insurance company. You are responsible for any amount not paid by your insurance.

4. You also understand and acknowledge that you are personally responsible to pay the entities listed above in full for any services that your health insurer will not cover due to non-payment of your health insurance premiums.

5. We do not wish to have anyone denied medical care because of the inability to pay. If you are unable to pay at the time of your service, we ask that you contact our office before the day of your visit to set up a mutually agreeable payment arrangement.

6. If a check is not honored by your bank you may be assessed a charge to cover the additional handling and bookkeeping fees. This charge will be in accordance with Florida law.

7. If you allow your account to become delinquent, we may find it necessary to take appropriate collection action. Any attorney fees, court costs, 30% collection fees and interest charges at 18% will be your responsibility.

Patient Signature

Date

Name:_____

Account #:_____

APPOINTMENT CANCELLATION / NO SHOW POLICY FOR GASTROENTEROLOGY ASSOCIATES OF OCALA

Gastroenterology Associates of Ocala is privileged to provide medical and surgical treatment for our patients. We work diligently to maintain our high level of personalized service and strive to accommodate our patients' needs for office visits in a timely manner.

This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of our other patients. Therefore, we have developed this policy regarding failure to keep appointments or cancelling appointments without adequate notice.

We respectfully request your understanding and agreement to our policy as it is stated below.

OFFICE APPOINTMENTS

We will give you a reminder call 48 hours in advance of your scheduled appointment. Any patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours prior to their appointment will be required to pay a fee of $45.00 in order to schedule a new office visit. For Monday appointments, cancellations must be made by noon on the preceding Friday. This fee will have to be paid prior to your next appointment.

AMBULATORY SURGICAL CENTER APPOINTMENTS

Any patient who fails to keep an appointment or who cancels or reschedules a surgery less than 72 hours in advance of their appointment will be charged a fee of $100.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday.

FEES

All fees charged by Gastroenterology Associates pursuant to this No Show/Cancellation policy are not payable by your insurance company.
All fees are payable on or before your next office visit with your Gastroenterology physician or within 30 days of receipt of a billing statement from Gastroenterology for that fee, whichever is earlier. Please remember that it is your responsibility to make certain that we have updated, accurate phone numbers so that we may contact you.

If a patient fails to keep three appointments, or fails to give adequate notice on three occasions, the practice will have the right to dismiss that patient.

Thank you for your consideration and understanding of our policy.

Patient Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

Endoscopy Center of Ocala - This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.
☒ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
☒ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
☒ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
☒ You have the right to request that we amend your information.
☒ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
☒ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Center Leader (352)732-8905

I,_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____Date:_____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness seeking acknowledgement
_____Date:_____

Consent for Treatment - Addendum

July 1, 2020

Governor DeSantis has signed into law a requirement to obtain a specific consent prior to performing pelvic examinations (including rectal exams). Please review the following and indicate your acceptance by signing below.

I understand that my medical care may require a pelvic examination, and that a pelvic examination may be required at future visits with Gastroenterology Associated of Ocala. By signing below, I give my express consent to any and all medically appropriate examinations conducted now or in the future by a health care provider, medical student or student training as a health care provider that is employed or contracted with the Endoscopy Center of Ocala, Inc DBA Gastroenterology Associates of Ocala.

_____

Patient signature

_____

Patient name (printed)

_____

Date

_____

Witness signature