THESE FORMS MUST BE COMPLETED AND RETURNED AT LEAST 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT FOR ONLINE DRUG INTERACTION SCREENING

Florida Digestive Health Specialists

DBA

SARASOTA DIGESTIVE HEALTH SPECIALISTS

1801 Arlington St. Suite 101 Sarasota, FL 34239 Phone:(941)894-3490 Fax:(941) 702-8904

NEW PATIENT REGISTRATION FORM

LAST NAME :______________ FIRST NAME :______________ M.I. :_____ TODAY'S DATE:___/___/_____

ADDRESS :______________ CITY :______________ STATE :_____ ZIP :_________

AGE :_____ SEX : (Circle One) Male Female DATE OF BIRTH :___/___/_____ SOCIAL SECURITY NUMBER :_____-____-______

RACE/ETHNIC HERITAGE (Example: Caucasian/Irish-German.) :__________/__________ PREFERRED LANGUAGE :__________

HOME PHONE :__________ WORK PHONE :__________ EXT# :______ CELL PHONE :__________

MARITAL STATUS: (Please Circle One) Single Married Spouse's Name :______________ Widowed Divorced

Is the Patient Employed? Y/N _____ If a dependent child, is the child a student? Y/N _____

Employer/School Name :______________ Address :______________ Phone# :__________

SEASONAL RESIDENTS ONLY Pleas provide permanent address (out of area)

Address :______________ City :__________ State :_______ Zip Code :__________

EXTENDED INFORMATION

In case of an Emergency, or if patient is a minor, who may we contact in this local area on your behalf?

Name :______________ Relationship to the patient :__________

Address :______________ City :__________ State :_____ Zip :_________

Home Phone :__________ Work Phone :__________ Cell Phone :______________

ACCOUNT INFORMATION

Primary Care Physician's Name :______________ (Please Include First Name)

Referring Physician's Name :______________

Number of Insurance Policies :_____ (Please Circle the Applicable Insurance below)

Commercial HMO PPO Medicare Medicaid Worker's Comp Other No Insurance

- -

PLEASE CIRCLE YOUR ANSWER "YES OR NO" IF YES, DO NOT COMPLETE, SIMPLY GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.

YES NO 1. ARE YOU THE POLICY HOLDER OF YOUR INSURANCE?

IF NO, PLEASE GIVE THE FOLLOWING INFORMATION ABOUT THE POLICY HOLDER:

*Name :__________ *Date of Birth :___/___/_____ *Social Security # :____-____-______

*Phone Number If Different Than Patient's Number :______________

*Employer, If Applicable :______________ Employer's Telephone # :______________

*Employer's Address :______________ City :__________ State :_____ Zip :________

YES NO 2. DO YOU HAVE A SECONDARY INSURANCE?

YES NO 3. ARE YOU THE POLICY HOLDER OF THE SECONDARY INSURANCE POLICY?

IF YOU ANSWERED "NO" TO QUESTION # 3, PLEASE GIVE THE FOLLOWING INFORMATION ABOUT THE POLICY HOLDER:

*Name :__________ *Date of Birth :___/___/_____ *Social Security # :____-____-______

*Phone Number If Different Than Patient's Number :______________

*Employer, If Applicable :______________ Employer's Telephone # :______________

*Employer's Address :______________ City :__________ State :_____ Zip :________

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

WHAT IS YOUR PREFERED CONTACT PREFERENCE? (Circle One) Mail Telephone

May we call you at work? YES NO May we call you on your cell phone? YES NO

DO WE HAVE PERMISSION TO:

- Send a yearly appointment reminder to your home? YES NO
- Send test results to your home? YES NO

Leave the following information on your home answering machine/voice mail:

- Appointment Information YES NO
- Billing Information YES NO
- Medical Information YES NO

Leave the following information on your work answering machine/voice mail:

- Appointment Information YES NO
- Billing Information YES NO
- Medical Information YES NO

I give permission to share appointment information with the person(s) named below:

Name(s)_____

I give permission to share medical information with the person(s) named below:

Name(s)_____

I give permission to share billing information with the person(s) named below:

Name(s)_____

REASON FOR THE APPOINTMENT

_____

_____

SIGNED_____ DATE____/_____/_____

If signed by someone other than the patient, please indicate the relationship to the patient:

Parent Legal Guardian Legal Representative Other:_____

CONSENT FOR MEDICAL SERVICES & TREATMENT

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by Dr._____ as a physician of Sarasota Digestive Health Specialists and his/her designee(s)

FINANCIAL AGREEMENT

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing, unless prior arrangements have been made with our office. If not, the balance may be turned over for collection activity, at which time the undersigned shall be liable for fees generated by the collection process. The patient is responsible for deductibles and co-pays at the time of the appointment. If we do not participate in your insurance plan, payment is expected at the time service is rendered.

ASSIGNMENT OF BENEFITS

In the event that I am entitled to physician benefits of any and all types, I assign such benefits to Sarasota Digestive Health Specialists for services rendered to me. I authorize payment directly to Sarasota Digestive Health Specialists of all such insurance benefits payable to me. Such insurances include, but not limited to, private commercial insurance, Medicare, auto/liability insurance and authorize Sarasota Digestive Health Specialists to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

RELEASE OF INFORMATION

I also authorize Sarasota Digestive Health Specialists to release all or part of my medical record information when required or permitted by law or government regulation, including any physician(s) or healthcare provider responsible for continuing my care. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), hepatitis or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug use. I also give permission for this material to be transmitted by telefax. I understand that it is my responsibility to provide the sender with an accurate fax number if records are faxed. I understand that faxing records may result in transmission to the wrong number, I accept the risk of mis-transmission if my records are faxed, and release Sarasota Digestive Health Specialists of any liability for mis-transmission by fax.

INSURANCE PRECERTIFICATION

I understand that, before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance due to lack of authorization prior to treatment.

LIFETIME MEDICARE SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Sarasota Digestive Health Specialists for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicated Services or its agents any information needed to determine these benefits or benefits for related services.

_____ _____
Name of Beneficiary Medicare Number

LIFETIME MEDIGAP SIGNATURE AUTHORIZATION

I Request that payment of authorized Medigap benefits be made on my behalf to Sarasota Digestive Health Specialists for any services furnished to me. I authorize any holder of medical or other information about me to release any information needed to determine these benefits or benefits for related services.

_____ _____ _____
Name of Medigap Insurance Company Name of Beneficiary Medigap Policy Number

NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of Sarasota digestive Health Specialists Notice of Privacy Practices that describes how Sarasota Digestive Health Specialists may use and disclose my health information, and also describes my rights regarding my health information.

EVALUATION SERVICES AND FOLLOW-UP

I give permission for Sarasota Digestive Health Specialists and/or its agent(s) to contact me for the purpose of evaluation of the services rendered to me.
_____ YES _____NO

The undersigned certifies that he/she has read and understands the above, fully accepts all specified terms therein, and has received the information on patient rights, including the mechanism for initiation, review, and resolution of complaints and a copy of the Sarasota Digestive Health Specialists Notice of Privacy Practice.

_____ _____
Signature of Patient or Legally Authorized Representative Print Name of Patient or Legally Authorized Representative Date

_____ _____
Signature of Guarantor of Payment (If the guarantor is NOT the Patient, please state the relationship if other than the Patient.) Print Name of Guarantor of Payment Date

_____ _____
Signature of Witness Print Name of Witness Date

PATIENT FINANCIAL RESPONSIBILITY

- Payment is expected in full at the time of service for all patients without insurance, or insurance that pays you, the patient, directly and for those who have insurance companies that we do not participate with as providers.
- All co-pays are required at the time of service.
- Exclusions to this policy include Medicare, except for co-pays when applicable, Medicare replacement or managed care plans.
- **Your insurance is between you and your insurance company.** You will need to familiarize yourself with the way your insurance company works and pays for a test or procedure. **It is your responsibility to know if you need pre-authorization for a procedure or testing, which laboratory they require you use for lab work and whether or not your insurance company requires a referral.** It will also be necessary for you to contact your primary care physician should a referral be required. If you do not obtain a referral for a visit prior to your appointment, we may need to reschedule your appointment or the fee services may be your responsibility. Please contact your Primary Care Physician (PCP) and have him/her fax your referral directly to the office you will be seen at prior to the date of your appointment. Our office address, phone and fax number is: Sarasota Digestive Health Specialists 1801 Arlington Street Suite 101 Sarasota, FL 34239 Phone:(941)894-3490 Fax:(941)894-3494
- **If your insurance company sends a check for payment directly to you, you are responsible for signing the check over to us for payment services rendered.**
- If you have a balance due after the insurance company has paid us, you will be sent a statement itemizing the services rendered and the balance due.
- Our business office will bill your primary and secondary insurances, however proper billing requires we have accurate information regarding your insurance. A copy of your insurance cards and photo ID will be made at the time of your initial visit and kept in your chart. If your insurance changes, you will need to let the receptionist know, so he/she can update your insurance information for our billing office.
- **If we do not have accurate information regarding your insurance, a referral from your PCP, (if a referral is required), or pre-authorization for testing (if your insurance requires pre-authorization) at the time services are rendered, the entire balance may be your responsibility.**

Patient Signature_____ Date_____

Print Patient's Name_____

PATIENT HEALTH HISTORY

Name_____ Today's Date_____ D.O.B (MM/DD/YYYY)_____

DOCTOR & PHARMACY INFORMATION

Referring MD_____ Primary Care MD_____ Cardiologist_____

Pharmacy Name_____ Pharm. Phone #_____ Pharm. Address_____

Have you seen another Gastroenterologist in the last 3 Years? Y or N (Circle One)

If Yes: Physician's Name:_____ Date of Visit:_____ Reason:_____

INSURANCE INFORMATION

Company Name:_____ Member Name:_____

Member ID#_____ Group # / Name:_____

PRESCRIPTION MEDICATIONS (Write N/A If None)

Medication Name _____ Strength _____ How Often

_____

_____

_____

_____

_____

_____

_____

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_____

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_____

_____

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SUPPLEMENTS

Name Only

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_____

_____

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_____

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_____

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_____

_____

_____

_____

_____

Drug Allergies (Write N/A if None)_____

Conditions: (Past and Present) (Circle N/A If None) N/A

Alcoholism Arrhythmia Barrett's Colitis COPD Diverticulitis Heart Attack Hypertension Pacemaker

Anxiety Arthritis Cardiac Stent Colon CA Diabetes Gallbladder Hemorrhoids IBS Pancreatitis

Anemia Asthma Cirrhosis Colon Polyps Depression GERD Hepatitis Kidney Problems Stroke

Cancer (type)_____

Past Surgeries & Dates (Write N/A If None)

_____

_____

_____

_____

Previous Colonoscopy: Y or N Year_____ Where_____ MD_____

Previous Upper Endoscopy: Y of N Year_____ Where_____ MD_____

SOCIAL HISTORY

Alcohol: Y/ N How Much?_____ DAILY / WEEKLY Tobacco: Y/ N How Much? _____DAILY / WEEKLY

Former Tobacco Use: Y or N Caffeine (Coffee, Tea, Soda): Y or N How Much? _____ DAILY / WEEKLY

Family History of GI Problems and/or Cancer

Mother: _____ Father: _____ Sister: _____

Brother: _____ Children: _____ Other: _____