

GASTROINTESTINAL CONSULTANTS OF CENTRAL FL, LLC
PATIENT REGISTRATION FORM

2134 VINDALE RD,
TAVARES, FL 32778
PH (352) 383-7703
FX (352) 383-8875

1501 N HWY 441, BLDG 1600
LADY LAKE, FL 32159
NORTH FL UROLOGY

17075 CAGAN RIDGE BLVD
SUITE 100,
CLERMONT, FL 34714

DATE: _____ / _____ / _____ SS# _____ - _____ - _____

PRIMARY DR: _____ REFERRING DR: _____

PATIENT EMAIL: _____

PT LAST NAME: _____ PT NAME: _____

MI: _____ DOB: _____ / _____ / _____ MALE FEMALE

PT ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: _____ - _____ - _____ CELL #: _____ - _____ - _____

LANGUAGE: ENGLISH / SPANISH / OTHER: _____ ETHNICITY: HISPANIC / NOT HISPANIC

RACE: WHITE / HISPANIC / AFRICAN AMERICAN / INDIAN / OTHER: _____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / LEGALLY SEPARATED

EMPLOYED FULL TIME / EMPLOYED PART TIME / SELF EMPLOYED / STUDENT / DISABLED / RETIRED

EMPLOYER: _____ PHONE #: _____ - _____ - _____

EMERGENCY CONTACT

NAME: _____ LAST NAME: _____

PHONE #: _____ - _____ - _____ RELATIONSHIP: _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHONE: _____ - _____ - _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZED MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY BALANCE. I AUTHORIZED GASTROINTESTINAL CONSULTANTS OF CENTRAL FL, LLC OR INSURANCE COMPANIES TO RELEASE MY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

x _____ DATE: _____ / _____ / _____

Please complete this form to help the anesthesiologist and clinical staff provide better care for you on the day of your procedure. (PLEASE PRINT)

Please List all Medications, do not write "see list"

Check yes or no	YES	NO	Check yes or no	YES	NO
Loose Teeth			History of nausea		
Dentures/Partials			History of heartburn		
Glasses/Contacts			Hiatal Hernia		
Use a Mobility Aid			MRSA		
Glaucoma			HIV/AIDS		
Cataracts			History of Tuberculosis		
Seizures			Hepatitis Circle: A B C		
Black Outs (Syncope)			Kidney Trouble		
Stroke			Prostate Problems		
High Blood Pressure			Diabetes		
Heart Attack			Thyroid Trouble		
Angina (chest pain)			Blood Clotting Problems		
Irregular Heartbeat			History of Bleeding/Anemia		
Palpitations			Sickle Cell Disease		
Heart Failure			Jaundice		
Stents			Previous Problems with Anesthesia		
Valve Replacements			Family history of problems with anesthesia		
Rheumatic Fever			High fever after anesthesia		
Shingles			Any Head, Neck, or Back problems		
Bronchitis			History of Anxiety or Depression		
Asthma			Other problems:		
COPD			Stress Test in the last 18 months?		
Emphysema			Test completed at:		
Shortness of Breath			Do you have a pacemaker/defibrillator?		
Sleep Apnea			Brand:		
Do you use a CPAP/Bi-PAP			Cardiac cath in the last 18 months?		
Do you currently smoke			Test completed at:		
Have you ever smoked			Echocardiogram in the last 18 months?		
History of drug/alcohol abuse			Test completed at:		

Office use Only	
BP	/
P	
R	
T	
SpO2	
Ht/ WT/ BMI	/ /
FSBS	
IV Site	
Cath Size	
Fluids	
Time/BY	/
Arm Precaution	Y/N L/R
INR	HCG: pos neg

List your Drug Allergies

List Past Surgeries

Patient Name: _____ DOB: ___/___/___

Signature _____

Signed _____ M.D./CRNA

BOWEL SYMPTOMS

Pt Last Name: _____ Pt Name: _____

Date: ____/____/____

Which symptoms best describe you? (Please circle all apply, if you don't have problems with your bowel please leave page in blank)

- Accidental loss or leakage of stool – sometimes unable to make it to the bathroom in time.
- Bowel accident while unaware – no warning and or while asleep.
- Frequent, loos, watery stools
- Sudden or strong urge to go the bathroom
- Bowel accident when passing gas
- No bowel problems

1. How long have you had these symptoms? Month('s) ____ Iyrs ____ 2yrs ____ Years ____

2. Approximately how many bowel incidents do you have per week? _____, Times.

3. Have you tried medications to help your symptoms? Yes ____ No ____

If yes, what type of medication: _____, _____.

**On scale 0 – 10 how much symptom relief have this medication provide for you?
(Circle number)**

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

no relief

complete relief

Behavior modifications tried?

- Lifestyle changes: Yes __ No __
- Fiber: Yes __ No __
- Diet changes: Yes __ No __
- Physical therapy: Yes __ No __

**On scale of 0 – 10 what is your level of frustration with your bowel control symptoms?
(Circle 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 __

DA VINCI SURGICAL HEALTH / GASTRO INTETINAL CONSULTANTS

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Gastro Intestinal consultants of central FL, LLC for services rendered by him / her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by insurance. I authorize Gastro Intestinal Consultants of FL, LLC, to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefit.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Gastro Intestinal Consultants of Central FL, LLC to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____, give permission for Gastro Intestinal Consultants of Central FL, to release and obtain my medical records from Dr. _____
Phone number _____ - _____ - _____ Fax number _____ - _____ - _____ I also understand that this consent can be cancelled at any time with written cancellation in the future will have no effect on any records that may have already been released prior to the receipt of the written cancellation. This authorization will remain in effect as long I am a patient of Gastro Intestinal Consultants of Central FL.

ACKNOWLEDGEMENT FORM

Our notice of privacy practices information about how we may use, and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, you may obtain a revised copy by writing our practice or requesting a copy from the front desk staff. You have the right to request that we restricted how protected health information about you is used or released for treatment, payment, or health care operation. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about your treatment, payment, and health care operation as described above. You may have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Print Last Name: _____ Print Name: _____

Pt signature: _____ Date: ____/____/____.

Please include the names of any family or friends we may release your information:

Name: _____ Ph: _____ - _____ - _____ Relationship _____

Name: _____ Ph: _____ - _____ - _____ Relationship _____

Name: _____ Ph: _____ - _____ - _____ Relationship _____

NO SHOW NOTICE / PROCEDURES CANCELLATIONS

Your procedure is a time that has been set aside exclusively for you with Dr. Lal Nagabhairu M.D / Dr. Shams Tabrez M.D your gastroenterologist.

We understand that your time is very valuable to you, and to respect your time and our other patients, we required two business days' notice to change or cancel your appointment or procedures.

We understand we all have busy lives and things can come up last minute from time to time. However, last minute cancellations and no shows are subject a **\$50.00** cancellation fee.

Thank you, for your cooperation

Gastrointestinal Consultants of Central FL, LLC

Dr. Lal Nagabhairu M.D

Dr. Shams Tabrez M.D

Pt signature: _____ Date: ____/____/____

UNDERSTANDING COLONOSCOPY & EGD BILLING

Subject to four bills for one procedure they will be as follows:

- Facility charge (The place where your procedure is scheduled).
- Physician charge for the procedure itself
- Anesthesia charge
- Lab charge (For testing or if biopsies are taken)

Gastro Intestinal Consultants of Central FL and Premier Surgical Center make every effort to call your insurance company to verify coverage for your procedure.

THIS IS NO GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY. IT IS THE PATIENT'S RESPONSIBILITY to know the coverage of your policy. If you have questions regarding the coverage of your procedure, you need to contact your insurance company directly. **Gastro Intestinal consultants of central FL and Premier Surgical Center** can only estimate charges incurred for our Physician's and anesthesia services. If you have questions regarding any of the above-mentioned charges, please contact your insurance company or our billing department (352) 383 - 7703.

SCREENING COLONOSCOPY

A screening colonoscopy is usually covered 100% under your insurance preventative benefit. **HOWEVER**, while the doctor is performing your screening, he may find a polyp. He may at that time remove the polyp and have it sent for biopsy. While the main colonoscopy code should still be covered by your preventative benefit, there may be a portion that the patient may owe for that polyp or biopsy.

EGD (Upper Endoscopy)

An EGD is not covered 100%. Depending on your insurance plan you will be responsible for your deductible co-pay or coinsurance. The portion you are responsible for will be collected at the time of your procedure. Any money collected upfront is only the surgical facility. You will still receive your bill for the anesthesia and doctor.

Pt signature: _____ Date: ____/____/____.

FINANCIAL POLICIES

- 1. Please bring your insurance card to the office EVERY visit**
- 2. Your co-pay is due at the time of service before every appointment.**

3. How may I pay?

We accept payment by cash, credit card & care credit. If you have no insurance or if we are not able to verify insurance eligibility, we ask that you pay for the visit at the time of service.

4. Do I need a referral or pre- authorization?

If your insurance plan requires a referral and authorization from your primary care physician form your insurance, you need to contact your primary care physician or insurance company to be sure it has been obtained. IF WE HAVE NOT RECEIVED AN AUTHORIZATION PRIOR TO YOUR ARRIVAL AT THE OFFICE YOUR APPOINTMENT WILL BE RECHEDULED.

5. What is my financial responsibility for services?

It is your responsibility to verify that physicians or facility in which you are seeking treatment are an authorized provider under your insurance plan. If we do not have verification that you are covered by an insurance plan, you will expect to pay the charges in full at the time of the visit.

6. What if my visit is due to an accident or involves an Attorney?

You will need to pay at the time services are rendered. Any information you have on your case including:

- Accident date, injury, past procedures (etc.) you must bring in with you and tell the front office staff when you check in.**
- Your Attorney may provide you with a letter of protection (LOP), if for some reason we do not accept you LOP, then you will be responsible for payment in full at the time of service.**
- If your LOP is accepted, your Attorney must provide a check the day services are rendered.**

7. Balance and payment plans

It is your policies the we send out 3 patient billing statements for balance due. After which we Will roll your account over to an outside collection agency. To avoid this, please contact our Billing department. Anything that your insurance does not pay after 30 DAYS becomes your Responsibility. We realized medical bills involving health insurance can be very complicated. Our goal is you help you become aware of your responsibilities as an insured member. Our billing department can be reached at (352) 383 -7703 if you ever have any question or concerns over any of the above.

I have read, understand, and agree to the above Financial policy. I understand that charges not covered by my insurance company as well as applicable co-pay, deductibles and any charges older than 30 days from the date of service.

I authorize Gastro Intestinal Consultants or Central FL to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Gastro Intestinal Consultants of Central FL

Pt signature _____ Date: ____/____/____.