Gastroenterology Associates of West Florida

Digestive Diseases and Nutrition

Diplomates American Board of Gastroenterology.
Diplomates American Board of Internal Medicine

Phone: 727-846-7031 Fax: 727-846-7132

Primary Mailing Address:
10820 SR. 54, Ste. 201
Trinity, FL, 34655
Synovus Bank Building

Curtis Freedland, D.O.
Gastroenterology & Nutrition
Joseph Staffetti, M.D.
Gastroenterology
Dilip Ghanekar, M.D.
Gastroenterology

Welcome to our practice
This letter is to confirm your appointment.

Please complete the enclosed paperwork, which should be brought in with you at the time of your appointment. **PLEASE DO NOT MAIL.**

PLEASE CONTACT YOUR PHYSICIAN AND BRING IN ALL RELEVANT TESTS, INCLUDING LABORATORY, X-RAY, ETC.
PLEASE ALSO BRING A LIST OF YOUR CURRENT MEDICATIONS OR MEDICATION BOTTLES WHEN YOU COME IN.

Please remember to bring your photo ID, insurance cards, and any insurance co-pay. If you are a member of an HMO it is **your responsibility** to obtain the referral from your primary care physician. We advise that you call our office the day before your scheduled appointment to be sure we have received your referral (authorization). If we do not have the referral it will be necessary to reschedule the appointment.

****A $25.00 fee may apply for No-Show appointments****

☐ Curtis Freedland, D.O ☐ Joseph Staffetti, M.D. ☐ Dilip Ghanekar, M.D. ☐ Marianne Milos, PA-C

☐ Synovus Bank Building 2nd floor
10820 State Road 54, Suite 201
Trinity, FL, 34655

☐ Summit Medical Plaza
7515 State Road 52, Suite 105
Hudson, FL, 34667

Appointment
Time: _____ Date: _____

Please arrive 15 minutes early for your appointment
PLEASE BE COURTEOUS, IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT, KINDLY GIVE US 48 HOURS NOTICE.

WEB Address: gastrowestfl.com

Gastroenterology Associates of West Florida Patient Registration Form

Last Name	First Name		MI	**Email Address**:			
Date of Birth	Age	Sex	Social Security #	Single	Married	Divorced	Widowed
Home Address		Apt#	City			State	Zip
Home Address		Apt#	City			State	Zip
Home Phone	Cell Phone		Employer			Phone	
Name of Emergency Contact		Relationship	Address			Phone	
Pharmacy Name	Pharmacy Location			Pharmacy phone		Pharmacy FAX	
Referring Physician	Referring Physician Address			Referring Physician Phone			
Name of Primary Insurance			Name of secondary Insurance				

Authorizations & Acknowledgements: Your Initials Indicate Consent

Benefits	Initials	I request that payment of authorized benefits be made to **West Florida Medical Specialists.** I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services. I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any health care professional requiring this information in order to treat me. I hereby assign and authorize payment to **West Florida Medical Specialists** for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance claims or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges not directly reimbursed to **West Florida Medical Specialists** by any insurance policy, self-insurance program, or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.
Privacy	Initials Initials	I acknowledge that I have received a copy of the "Notice of Privacy Practices." I [ ] DO [ ] DO NOT authorize **Gastroenterology Associates of West Florida** and/or **West Florida Medical Specialists** to discuss my appointments, medical evaluation, treatment, and results to relatives or other persons as indicated: Authorized person(s)
Contact Rules	Initials Initials	I [ ] DO [ ] DO NOT authorize **Gastroenterology Associates of West Florida** and/or **West Florida Medical Specialists** to leave messages on my home answering machine regarding appointments, and to inform me that laboratory results are available. I realize I must call the office to obtain laboratory results. I [ ] DO [ ] DO NOT authorize **Gastroenterology Associates of West Florida** and/or **West Florida Medical Specialists** to contact me at work or leave messages for me at work.
Living Will	Initials	I acknowledge that I am aware of the need for Advance Directives and that I understand information is available if needed. I also acknowledge that: I [ ] DO [ ] DO NOT have Advance Directives (either a living will or a Durable Power of Attorney for Health Care). If I do not have such Advance Directives at this time, but establish them at a later date, I will provide the Office/Center a copy.
Transfer	Initials	I understand that in case of emergency at any of our offices, I will be transferred to the nearest hospital emergency room.

Patient/Legal Guardian/Authorized Person (signature) _____ Relationship if other than Patient _____ Date _____

Patient Health History Form

Please complete this history form while waiting to see your physician. All information is confidential and is helpful in your treatment.

Patient Name: Date of Birth: Age:

Last Colonoscopy: Last EGD: Today's Date:

History of Present Illness: What is the reason you are here:

Allergies (Food/Environmental/Drug)

Symptoms/Problems (check current symptoms you are having)

General
- ☐ Chills
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Weakness

Allergy/Immunology
- ☐ Animal allergy
- ☐ Food allergy
- ☐ Hay fever
- ☐ Hives
- ☐ Pollen allergy

Endocrine
- ☐ Bulging eyes
- ☐ Excessive thirst
- ☐ Excessive Urination
- ☐ Intolerant heat/cold

Pulmonary
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Night Sweats
- ☐ Shortness of breath
- ☐ Sputum Production
- ☐ Wheezing

☐

Hematology
- ☐ Bleeding disorders
- ☐ Enlarged lymph nodes
- ☐ Prior transfusions

Skin
- ☐ Hair/Nail changes
- ☐ Itching
- ☐ Rash

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Anorexia/Bulimia
- ☐ Black stools
- ☐ Bloody (red) stools
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Loss of bowel control
- ☐ Jaundice
- ☐ Bloating
- ☐ Gas
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Painful Swallowing
- ☐ Poor Appetite
- ☐ Rectal Pain

Eye, Ear, Nose, Throat
- ☐ Altered taste
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Post nasal drip
- ☐ Ringing in ears
- ☐ Voice changes
- ☐ Vertigo

Cardiovascular
- ☐ Chest pain
- ☐ Leg pain with extension
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Joint Pain
- ☐ Muscle Pain

Men only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge or sores

Women only
- ☐ Abnormal pap smear
- ☐ Abnormal vaginal bleeding
- ☐ Breast lump/discharge
- ☐ Hot flashes
- ☐ Vaginal infections

Urological
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Loss of urine control
- ☐ Painful urination
- ☐ Sexual dysfunction
- ☐ Urinary tract infections

Neurologic/Psych
- ☐ Fainting
- ☐ Hallucinations
- ☐ Memory Loss
- ☐ Phobias
- ☐ Numbness
- ☐ Speech Problems
- ☐ Tremor
- ☐ Weakness

Patient Name: **DOB:**

Conditions/Illnesses you currently have or have had in the past

Endocrine
- ☐ Thyroid problems
- ☐ Cholesterol/Triglycerides
- ☐ Goiter
- ☐ Diabetes

Pulmonary
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Blood clot-leg/lung
- ☐ COPD
- ☐ Bronchitis
- ☐ Leukemia

Hematology/Oncology
- ☐ Anemia
- ☐ Cancer
- ☐ Lymphoma
- ☐ Leukemia

Skin
- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Eczema

Gastrointestinal
- ☐ Alcoholism
- ☐ Colon Polyps
- ☐ Colon Cancer
- ☐ Colitis
- ☐ Crohn's
- ☐ Cirrhosis
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Gallstones
- ☐ Hemorrhoids
- ☐ Hepatitis A, B, C
- ☐ Hernia
- ☐ Irritable Bowel
- ☐ Pancreatitis
- ☐ Reflux
- ☐ Ulcers
- ☐ Vomiting blood

Eye, Ear, Nose, Throat
- ☐ Glaucoma
- ☐ Ear/Hearing Problems
- ☐ Mastoiditis
- ☐ Sinus Problems
- ☐ Tonsillitis
- ☐ Vision Problems

Cardiovascular
- ☐ Angina
- ☐ Atrial Fib
- ☐ Abnormal heart rhythm
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Rheumatic fever
- ☐ Varicose veins
- ☐ Vascular heart disease

Urological
- ☐ Prostate problems
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Venereal diseases

Neuro/Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Headaches/Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Polio
- ☐ Seizures/Tremors
- ☐ Suicide attempt
- ☐ Strokes/TIA
- ☐ Schizophrenia

Surgery- Write the year next to any surgery you have had

- ☐ Aneurysm
- ☐ Appendix
- ☐ Adhesions
- ☐ Artificial Heart Valve
- ☐ Bypass (heart)
- ☐ Bypass (non-cardiac)
- ☐ Back surgery
- ☐ Gastric Bypass
- ☐ Bladder
- ☐ Breast (right or left)
- ☐ Cataract (R or L)
- ☐ C-Section
- ☐ Defibulator
- ☐ Gallbladder
- ☐ Heart Catheterization
- ☐ Heart stent
- ☐ Hysterectomy (was it left___)
- ☐ Joint replacement (hip) (knee) (R or L)
- ☐ Hemorrhoids
- ☐ Hernia (R or L)
- ☐ Kidney (R or L)
- ☐ Lung (R or L)
- ☐ Ovary
- ☐ Pacemaker
- ☐ Prostate
- ☐ Skin cancer/Melanoma
- ☐ Spleen
- ☐ Thyroid Gland
- ☐ Tonsils
- ☐ Tubal Ligation
- ☐ Ulcer
- ☐ Intestine/Colon/Rectum

Hospitalizations and other surgical procedures not listed above:

Year: Reason/Outcome:

Hospital:

Other conditions/illnesses that are not listed above or on previous page:

Social History:

☐ Tobacco # of packs daily How many Years? Year stopped Have discussed quitting? Y or N

☐ Alcohol Amount Daily Weekends How many years? Years stopped

☐ Married ☐ Divorced ☐ Single Years married Name of spouse: # of children:

Family History: Fill in health information about your family

Check if your blood relatives had any of the following			Check if your blood relatives have had any of the following		
Disease:		Relationship to you:	Disease:		Relationship to you:
	Colon Cancer			Irritable Bowel	
	Colon Polyps			Celiac Disease	
	Other Cancers			Hepatitis	
	Crohn's Disease			Liver Disease	
	Ulcerative Colitis			Other	

I have filled out this form completely and all areas that are not checked are negative

Signature: Date:

Reviewed by: Date: Updated:

Notice of Privacy Practices for Protected Health Information (HIPAA)

This notice describes how medical information about you may be used, disclosed, and how you may get access to this information. Please review it carefully!

We safeguard information about your health and person

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance, and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical uses and disclosures of medical information:
We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers, and for healthcare operations. Outside of our office, we restrict the disclosure to those people, entities, and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, and extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (death, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors.
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Workers compensation
- Disaster relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any Specific authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights:

You have the right to:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available, and within 60 days if it is not readily available. You may also get an electronic copy if we have one available
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days
- Receive an accounting of any disclosures made from your record over the past six years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent. We cannot disclose self-pay services if you object.
- Request confidential communications. All communications in our office are confidential. You may specifically request that all communications be confidential with a written request directed to our office
- Not have your protected health information sold for marketing purposes
- Opt out of receiving fund-raising communications
- Receive a copy of this notice by printing it, or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by law to maintain the privacy of your personal information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our PRIVACY OFFICER at our office.

Patient Name: _____ Date Signed: _____

Patient Signature: _____

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

Effective date of notice:
Amended dates: February 2011

Notice to All Patients

Please be advised that you will receive a separate bill for any Diagnostic and/or Laboratory tests. Because of changes in Medicare rules, your Insurance Company may not pay for all of the Diagnostic and/or Laboratory tests that the doctors feel are necessary to diagnose your condition. You will be responsible for any tests not paid by your insurance company.

This will also include your outpatient procedure benefits. We will verify your insurance for the doctor's portion only. The facility will do their own verification. Additional bills you may incur will include the facility, anesthesia, and pathology if biopsies are taken.

As a courtesy to our patients, our office will file all primary and secondary insurances for all services rendered in our office. When the insurance company pays the patient directly, we will expect payment at time of service.

In order for us to continue this courtesy we must set a time limit for payment. Please read and sign the statement below.

****

If Payment is not received within 90 days from Date of Service from both my primary and secondary insurance, I agree to pay the balance on my account in full. Also, if the insurance company issues a check to me, I will promptly turn it in to this office. I also understand that all Diagnostic and Laboratory tests will be billed separately and not from this office.

Date: _____ Signature: _____

1. Have you had any recent labs drawn?

   Where? _____

   When? _____

2. Have you had any recent X-Rays (i.e. Ultrasound, MRI, CT Scans)?

   Where? _____

   When? _____

3. Have you had any endoscopic exams (i.e. Colonoscopy/EGD)?

   Where? _____

   When? _____

4. Have you been recently hospitalized or in the Emergency Room?

   Where? _____

   When? _____

If you have copies of any results or can obtain them, please bring them with you to your office appointment or have them faxed to: 727-846-7132

Thank you

Medication List

(Please include over-the-counter medications as well as any herbal medications)

Patient Name: DOB:

Pharmacy Name: Phone #:

Drug:	Dosage:	X Per Day	Reason:
Drug:	Dosage:	X Per Day	Reason:
Drug:	Dosage:	X Per Day	Reason:
Drug:	Dosage:	X Per Day	Reason:
Drug:	Dosage:	X Per Day	Reason:
Drug:	Dosage:	X Per Day	Reason:
Drug:	Dosage:	X Per Day	Reason:
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Drug:	Dosage:	X Per Day	Reason:
Drug:	Dosage:	X Per Day	Reason:

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date:

Date of Birth:

Social Security #:

TO: Phone:
Fax:

Please send the complete medical records in your possession concerning my illness and/or treatment during this period to 727-846-7132:

- I acknowledge that the released information may contain HIV testing, Substance abuse, or mental illness information
- I understand that I may revoke this authorization by notifying, in writing, the medical records department, knowing that previously disclosed information would not be subject to my revoke request.

Patient Signature: Date:

Witness:

Relationship: