Gastroenterology Associates of West Florida

Digestive Diseases and Nutrition

Diplomates American Board of GastroenterologyDiplomates American Board of Internal Medicine

7515 SR 52, Suite 105
Hudson, Florida 34667.6757
Primary Mailing Address:
5622 Marine Parkway, Suite 14
New Port Richey, Fl 34652.4330

(727) 846-7031 **Fax (727) 846-7132**

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 for consultation.

Please complete the enclosed paperwork, which should be brought in with you at the time of your appointment.

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 insurance cards and the 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 the referral. If we do not have the referral it will be necessary to reschedule the appointment.

****Please arrive 15 minutes early for your Appointment****

We are looking forward to meeting you.

Curtis Freedland, D.O **Joseph Staffetti, M.D.** **Dilip Ghanekar, M.D.**

❑ 5622 Marine Parkway, Suite 14
New Port Richey, FL 34652

❑ Summit Medical Plaza
7515 State Road 52, Suite 105
Bayonet Point, FL 34667

❑ 1138 Commercial Way
Spring Hill, FL 34606

Appointment:

Time: _____ Date: _____

PLEASE BE COURTEOUS, IF YOU ARE UNABLE TO KEEP APPOINTMENT, KINDLY GIVE 48 HOURS NOTICE.

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 Doctor may feel are Medically Necessary to diagnose your condition. You will be responsible for any tests not paid by your insurance company.

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:_____

PATIENT INTRODUCTION

PLEASE PRINT

DATE _____

PATIENT _____ SOCIAL SECURITY # _____
FIRST MIDDLE LAST

FLORIDA ADDRESS _____ HOME PHONE # _____

CITY/STATE _____ ZIP _____

SEX: ❑ M ❑ F AGE' _____ BIRTH DATE _____ ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

PATIENT EMPLOYED BY _____ BUS. PHONE _____

ADDRESS _____ OCCUPATION _____

CITY/STATE _____ ---

OUT OF STATE ADDRESS (ALSO NEEDED IF NOT A PERMANENT FLORIDA RESIDENT)

ADDRESS _____ HOME PHONE # _____

CITY/STATE _____ ZIP _____

PATIENT EMPLOYED BY _____ BUS. PHONE _____

ADDRESS _____ OCCUPATION _____

CITY/STATE _____ ZIP _____

RESPONSIBLE PARTY

(IF DIFFERENT THAN ABOVE) _____ SOCIAL SEC. # _____

RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ PARENT ❑ GUARDIAN ❑ _____

HOME ADDRESS _____ HOME PHONE _____

CITY/STATE _____ ZIP _____

EMPLOYED BY _____ BUS. PHONE _____

BUSINESS ADDRESS _____ DATE OF BIRTH _____

CITY/STATE _____ ZIP _____

HEALTH INSURANCE COVERAGE: ❑ MEDICARE if _____ MEDICAID # _____

❑ HMO _____
COMPANY NAME GROUP # ID #

❑ OTHER COVERAGE _____
COMPANY NAME GROUP # ID #

COMPANY ADDRESS _____

CITY/STATE _____ ZIP _____

IN CASE OF EMERGENCY, NOTIFY _____ PHONE # _____

YOUR PHARMACY _____ PHONE # _____

REFERRED BY _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to physician of benefits due me for his services as described above. I understand I am financially responsible for charges not covered by this authorization.

DATE Signature

RELEASE OF INFORMATION: I hereby authorize the physician and/or supplier to release any information required to process this claim form.

DATE Signature

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AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

PATIENTS NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

THE INDIVIDUAL OR ENTITY AUTHORIZED TO RECEIVE MY HEALTH INFORMATION/ MEDICAL RECORDS:

1. _____
2. _____
3. _____

Please indicate if you would like to receive phone calls about appointments, lab results, Test results, or other health information, etc. ( ) yes ( ) no
May we leave this information on your answering machine or voice mail? ( ) yes ( ) no If yes what information may we leave? Appointment information ( ) lab results ( )
Test results ( )
The phone number where you would like to receive calls regarding health information: alternate number:

I understand that if the person or entity that receives my health information is not a health care provider the information can be re-disclosed and is no longer ~~covered under the federal pr~~ivacy regulations. Th~~erefore I release my healthcare~~ provider and it's
employees from liability arising from this disclosure of health 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.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Patient name_____ Date_____

Patient signature_____

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Notice of Privacy for:
Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect or domestic violence.
- Appointment reminders to household members or answering machines
- Sign-In logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy office who is Pat Hernandez and can be reached at: (727) 846-7031 regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Patient name_____ Date_____

Patient signature_____

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Account Number _____

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: _____ Today's Date: _____
Age: _____ Date of Birth: _____ Last Colonoscopy_____ Last EGD_____ ☐ **Updated** as of _____

HISTORY OF PRESENT ILLNESS: What is the main reason you are here:

MEDICATIONS List any medications you are taking, doses and frequency

Attached ☐

ALLERGIES (Food/Environmental/Drug)

Attached ☐

SYMPTOMS/PROBLEMS Check √ symptoms you have had in the past year. Also circle the major symptoms.

GENERAL ☐	**HEMATOLOGY** ☐		☐ Bleeding gums	**WOMEN Only** ☐
☐ Chills	☐ Bleeding disorders		☐ Hoarseness	☐ Abnormal Pap Smear
☐ Fever	☐ Enlarged lymph nodes		☐ Nosebleeds	☐ Abnormal Vaginal Bleeding
☐ Weight loss	☐ Prior transfusions		☐ Post nasal drip	☐ Breast lump / discharge
☐ Weight gain	**SKIN** ☐		☐ Ringing in ears	☐ Hot flashes
☐ Weakness	☐ Hair/Nail changes		☐ Voice changes	☐ Vaginal infections
ALLERGY/IMMUNOLOGY ☐	☐ Itching	☐ Rash	☐ Vertigo	**UROLOGICAL** ☐
☐ Animal allergy	**GASTROINTESTINAL** ☐		**CARDIOVASCULAR** ☐	☐ Blood in urine
☐ Food allergy	☐ Abdominal pain		☐ Chest pain	☐ Difficult urination
☐ Hay fever	☐ Anorexia / Bulimia		☐ Leg pain with exertion	☐ Frequent urination
☐ Hives	☐ Black stools		☐ Palpitations	☐ Loss of urine control
☐ Pollen allergy	☐ Bloody (red) stools		☐ Poor circulation	☐ Painful urination
ENDOCRINE ☐	☐ Constipation		☐ Rapid heart beat	☐ Sexual dysfunction
☐ Bulging eyes	☐ Difficulty swallowing		☐ Swelling of ankles	☐ Urinary tract infections
☐ Excessive thirst	☐ Loss of bowel control		**MUSCULOSKELETAL** ☐	**NEUROLOGIC / PSYCH** ☐
☐ Excessive urination	☐ Jaundice		☐ Fibromyalgia	☐ Fainting
☐ Intolerant heat/cold	☐ Bloating	☐ Gas	☐ Joint Pain	☐ Hallucinations
PULMONARY ☐	☐ Diarrhea	☐ Heartburn	☐ Muscle Pain	☐ Memory loss
☐ Chronic cough	☐ Nausea	☐ Vomiting	☐	☐ Phobias
☐ Coughing up blood	☐ Painful swallowing		**MEN Only** ☐	☐ Numbness
☐ Night sweats	☐ Poor Appetite		☐ Erection difficulties	☐ Speech problems
☐ Shortness of breath	☐ Rectal Pain		☐ Lump in testicles	☐ Tremor
☐ Sputum Production	**EYE, EAR, NOSE, THROAT** ☐		☐ Penis discharge or sores	☐ Weakness
☐ Wheezing	☐ Altered taste		☐	☐

Patient Name: _____

CONDITIONS/ILLNESSES you currently have or have had in the past.

Attached □

ENDOCRINE □	GASTROINTESTINAL □	EYE, EAR, NOSE, THROAT □	UROLOGICAL □
☐ Thyroid problems	☐ Alcoholism	☐ Glaucoma	☐ Prostate problem
☐ Cholesterol/Triglycerides	☐ Colon polyps	☐ Ear/ Hearing Problems	☐ Kidney disease
☐ Goiter ☐ Diabetes	☐ Colon cancer	☐ Mastoiditis	☐ Kidney stones
PULMONARY □	☐ Colitis ☐ Crohns Dx	☐ Sinus problems	☐ Venereal diseases
☐ Asthma ☐ Sleep Apnea	☐ Cirrhosis	☐ Tonsillitis	**NEURO / PSYCHIATRIC** □
☐ Tuberculosis	☐ Diverticulosis	☐ Vision problems	☐ Anxiety
☐ Blood clot –leg/lung	☐ Diverticulitis	**CARDIOVASCULAR** □	☐ Depression
☐ COPD ☐ Bronchitis	☐ Gallstones	☐ Angina ☐ Atrial Fib	☐ Bipolar
☐ Pneumonia	☐ Hemorrhoids	☐ Abnormal heart rhythm	☐ Headaches/Migraines
HEMATOLOGY/ONCOLOGY □	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Congestive Heart Failure	☐ Multiple sclerosis
☐ Anemia	☐ Hernia	☐ Heart Attack	☐ Parkinson's
☐ Cancer ☐ Lymphoma	☐ Irritable Bowel	☐ High blood pressure	☐ Polio
☐ Leukemia	☐ Pancreatitis	☐ Mitral valve prolapse	☐ Seizures / Tremors
SKIN □	☐ Reflux	☐ Rheumatic Fever	☐ Suicide attempt
☐ Psoriasis ☐ Dermatitis	☐ Ulcers	☐ Varicose veins	☐ Strokes / TIA
☐ Eczema	☐ Vomiting Blood	☐ Valvular Heart Disease	☐ Schizophrenia

SURGERY - write the year next to any surgery you have had

Attached □

☐ Aneurysm	☐ Bladder	☐ Hysterectomy What is left? _____	☐ Pacemaker
☐ Appendix	☐ Breast (Right Or Left)		☐ Prostate
☐ Adhesions	☐ Cataract (R) (L)	☐ Joint Replacement (Hip) (Knee) (R) (L)	☐ Skin Cancer/Melanoma
☐ Artificial Heart Valve	☐ C-Section		☐ Spleen
☐ Bypass (Heart)	☐ Defibrillator	☐ Hemorrhoids	☐ Thyroid Gland
☐ Bypass (Non Cardiac)	☐ Gallbladder	☐ Hernia (Right Or Left)	☐ Tonsils
☐ Back Surgery	☐ Heart Catheterization	☐ Kidney (R) (L)	☐ Tubal Ligation
☐ Gastric Bypass	☐ Heart Stent	☐ Lung (R) (L)	☐ Ulcer
☐	☐	☐ Ovary	☐ Intestine/Colon/Rectum

HOSPITALIZATIONS and other SURGICAL PROCEDURES not listed above:

Attached □

Year	Hospital	Reason for Hospitalization and Outcome

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 Yes □ No □ NA □
☐ Alcohol	Amount daily	Weekends	How many years	Year stopped
☐ Married	☐ Divorced	☐ Single	Years married: Name of spouse:	# of Children:

FAMILY HISTORY Fill in health information about your family.

Attached □

	Check if your blood relatives had any of the following: Disease:	Relationship to You:		Check if your blood relatives had any of the following: 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 _____