Gastroenterology Associates of West Florida

Digestive Diseases and Nutrition

Diplomates American Board of Gastroenterology
Diplomates American Board of Internal Medicine

Primary Mailing Address:
5622 Marine Parkway, Suite 14
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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.

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

☐ 14153 Yosemite Drive, Suite 203
Hudson, FL 34667

Appointment:

Time: _____ **Date:** _____

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

****Please arrive <u>15 minutes</u> early for your Appointment****

Web Address: gastrowestfl.com

Gastroenterology Associates of West Florida Patient Registration Form

PATIENT INFORMATION – PLEASE PRINT CLEARLY

Last Name			First Name	MI	□ Dr. □ Mr. □ Mrs. □ Ms. □ Miss
Date of Birth	Age	Sex	Social Security #		□ Single □ Married □ Divorced □ Widowed
Home Address			Apt #	City	State / Zip
Second Home Address			Apt. #	City	State / Zip
Home Phone	Cell Phone		Employer		Phone
Name of Responsible Party			Address		Phone
Name of Emergency Contact	Relationship		Address	Home Phone	Cell 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 healthcare 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 policy 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 incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those 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	I acknowledge that I have received a copy of the "Notice of Privacy Practices."
	INITIALS	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	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.
	INITIALS	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 with a copy.
Transfer	INITIALS	I understand that in case of an 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 Signed**

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Social Security 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 √ current symptoms you have having

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 _____

Notice of Privacy Practices for Protected Health Information (HIPAA)

"This Notice Describes How Medical Information About You May Be Used And 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 our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, 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 (deaths, 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)
- Worker's compensation
- Disaster Relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written 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 last 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 supercede the typical disclosures noted above. You may revoke or restrict the 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 health 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 <u>PRIVACY OFFICER</u> at our office.

_____ _____

Patient Name Patient Signature

Date Signed_____

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 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:_____

1. HAVE YOU HAD ANY RECENT LABS DRAWN?

   Where?_____

   When? _____

2. HAVE YOU HAD ANY RECENT X-RAYS (i.e. US, 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 ER?

   Where?_____

   When? _____

IF YOU HAVE COPIES OF ANY RESULTS OR CAN OBTAIN THEM, PLEASE BRING THEM WITH YOU TO YOUR OFFICE APPOINTMENT.

THANK YOU