Patient Demographics Sheet

PLEASE PROVIDE YOUR PHARMACY INFORMATION BELOW:

PREFERRED PHARMACY:
PHARMACY LOCATION:
PHARMACY PHONE NUMBER:

	FOR OFFICE USE ONLY
	Dr. Goldblatt
	Dr. Brown

Last Name:	First Name:		M.I.
Address:		Home Phone	
Address:		Work Phone	
City:	State	Cell Phone	
Zip Code:	Sex M ☐ F ☐	Fax Phone	
Are you Employed? Yes ☐ No ☐		Soc Sec #	
Employer/School:		Date of Birth	
Employer Address:		Marital Status	Married ☐ Single ☐
		Email:	
Spouse/Nearest Relative:		Phone:	

MEDICARE PATIENTS ONLY **Medicare ID#**

Do you have any other insurance? Yes ☐ No ☐ If yes, complete appropriate section below (Primary or Secondary)
Is Medicare your Primary or Secondary Coverage? Primary ☐ Secondary ☐ Don't Know ☐
Do you have *any type* of *Medicare + Choice (Medicare Replacement Policy)*, such as Cigna Healthcare for Seniors, HealthNet, or Humana Gold Plus Plan? Yes ☐ No ☐
If yes, what?

AHCCCS PATIENTS ONLY **AHCCCS ID#**

Plan – Mercy Care ☐ AZ Physicians IPA ☐ Cigna Community Choice ☐ Other ☐
Do you have any other insurance? Yes ☐ No ☐ If yes, complete Primary Insurance area below
Is AHCCCS your Primary or Secondary Coverage? Primary ☐ Secondary ☐ Don't Know ☐

ALL PATIENTS

Primary Insurance Co:	Group #
Subscriber Name:	ID#
Subscriber Employer:	Subscriber's Birth Date:
Employer Address:	
Subscriber's Soc Sec #	Subscriber's Relationship to You:
Secondary Insurance Co:	Group #
Subscriber Name:	ID#
Subscriber Employer:	Subscriber's Birth Date:
Employer Address:	
Subscriber's Soc Sec #	Subscriber's Relationship to You:

Primary Care Physician:	Phone
Address:	
Referring/Other Physician:	Phone
Address:	
Additional Physician(s):	Phone
Address:	

I HEREBY CERTIFY THAT I AM NOT COVERED BY HEALTH INSURANCE PLANS &/OR DISCOUNT CARDS OTHER THAN THOSE LISTED ABOVE. I UNDERSTAND THAT FAILURE TO DISCLOSE ALL INSURANCE INFORMATION WILL BE TAKEN AS MY ACKNOWLEDGEMENT THAT THERE ARE NO MEDICAL BENEFITS FOR AFFILIATED CRS TO FILE. By signing below, I authorize the surgeon listed above to release all of my health information including, but not limited to, AIDS/HIV and other communicable disease information, behavior health care, psychiatric care, alcohol and/or drug abuse treatment, if any, unless specifically excepted: _____. I authorize payment of medical benefits to the AFFILIATED surgeon listed above for all services rendered from this day forward. By signing below I authorize the above AFFILIATED surgeon to release any information to any other physician(s) listed above including my diagnosis and medical records for any treatment/examination rendered. I hereby also grant permission for the above AFFILIATED surgeon and/or staff to act as my attorney, in fact, for purposes of appealing a future medical claim in the event my insurer requires an appeal for an initially denied claim.

_____ _____

Patient Signature Date

Patient Medical History Form

Date	Last Name	First Name	M.I.

SYMPTOMS - Do you currently have any of these symptoms?

	YES	NO
Constitutional Symptoms		
Fever	☐	☐
Chills	☐	☐
Weight Loss	☐	☐
Loss of Appetite	☐	☐
Eyes		
Blurred Vision	☐	☐
Double Vision	☐	☐
ENT		
Trouble Swallowing	☐	☐
Loss of Hearing	☐	☐
Cardiovascular		
Chest Pain	☐	☐
Shortness of Breath	☐	☐
Palpitation	☐	☐
if yes, Defibrillator?	☐	☐
Respiratory		
Chronic Cough	☐	☐
Breathing Difficulty	☐	☐
Genito-Urinary		
Painful Urination	☐	☐
Difficult Urination	☐	☐

	YES	NO
Gastrointestinal		
Nausea/Vomiting	☐	☐
Abdominal Pain	☐	☐
Diarrhea	☐	☐
Blood in Stool	☐	☐
Constipation	☐	☐
Musculo-Skeletal		
Arthritis	☐	☐
Integumentary		
Skin Rashes	☐	☐
Neurological		
Muscle Weakness	☐	☐
Strokes	☐	☐
Psychiatric		
Change in Personality	☐	☐
Hematologic/Lymphatic		
Lymph Node Swelling	☐	☐
Bleed or Bruise Easily	☐	☐
If yes, why? _____		
Other		
Sleep Apnea	☐	☐
if yes, CPAP machine?	☐	☐
is CPAP being used?	☐	☐

Height _____ Weight _____

Surgery / Major Illnesses	Reason for Surgery	Year

If you were faced with a life threatening situation, would you permit a transfusion of blood?

☐ Yes ☐ No

Medications (including aspirin)	Dosage	Frequency	Reason for Medication

Allergies to Medications and Foods	Allergies to Medications and Foods

PLEASE CONTINUE TO NEXT PAGE…….

Patient Medical History Form (continued)

Date	Last Name	First Name	M.I.

			Hospitalized?	
MEDICAL ILLNESSES	**YES**	**NO**	**YES**	**NO**
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
GI Disease (ulcers, diverticulitis, etc.)	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐	☐
Other	☐	☐	☐	☐
Other	☐	☐	☐	☐

COLONOSCOPY HISTORY	**YES**	**NO**
Have you previously had a colonoscopy?	☐	☐
If Yes, please provide date/year		
If Yes, please provide Dr. Name/Location		

FAMILY HISTORY	**Living**	**Deceased**	**Significant Medical Conditions**	**Cause of Death (if applicable)**	**Age at Death**
Father	☐	☐			
Mother	☐	☐			
Brother(s)	☐	☐			
Brother(s)	☐	☐			
Sister(s)	☐	☐			
Sister(s)	☐	☐			

FAMILY HISTORY OF	**Yes**	**No**	**Relationship to Patient**
Colon Polyps	☐	☐	
Colon or Rectal Cancer	☐	☐	
Female Cancer (Breast, Cervical, Ovarian, Uterine)	☐	☐	
Crohn's Disease	☐	☐	
Ulcerative Colitis	☐	☐	

SOCIAL HABITS	**Yes**	**No**	
Do You Smoke?	☐	☐	How Much?
Drink Alcohol?	☐	☐	How Much?
Employed?	☐	☐	Occupation?

Acknowledgment of Receipt of Privacy Notice

Original to be maintained in Patient's permanent medical record.
Affiliated Colon and Rectal Surgeons, P.C.

I acknowledge that the doctor's office and Surgicenter's Notice of Privacy Practices are available to me for my review.

Patient or legally authorized individual signature	Date
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal rep, etc.)

Important - For All Medicare Patients

Please Read All Items Carefully Before Signing – Ask Our Office Staff for Assistance If Needed

Medicare helps pay for colorectal cancer screening tests. People with Medicare Part B coverage who are age 50 or older are eligible for colorectal cancer screenings.

COLONOSCOPY--HIGH RISK INDIVIDUALS, SCREENING ONLY, G0105

If you are at high risk for colorectal cancer, Medicare covers a screening colonoscopy every 2 years. You pay 20% of the Medicare approved amount after the yearly Part B deductible. Your risk is greater if you have a history of inflammatory bowel disease, colorectal cancer, or polyps, and if you have a family history of colorectal cancer or polyps, or have certain hereditary syndromes. Family history must relate to a sibling, parent or child.

COLONOSCOPY--AVERAGE RISK INDIVIDUALS, SCREENING ONLY, G0121

Beginning July 1, 2001, if you are at average risk (i.e., not at high risk) for colorectal cancer, Medicare will cover a screening colonoscopy every 10 years. You pay 20% of the Medicare approved amount after the yearly Part B deductible. However, if you are at average risk and have had a covered flexible sigmoidoscopy, you must wait 4 years to be eligible for Medicare coverage of a colonoscopy.

FLEXIBLE SIGMOIDOSCOPY—SCREENING ONLY, G0104

Screening flexible sigmoidoscopy is covered once every 4 years. You pay 20% of the Medicare approved amount after the yearly Part B deductible.

If the requirements mentioned above are not met, Medicare will not cover the procedure. Medicare may deny the claim because it does not meet the statutory time frame or for other reasons unbeknownst to us. Regardless of the reason for denial, the beneficiary is liable for the entire expense of the procedure.

Beneficiary Agreement:

I have been notified by my physician of the above Medicare colorectal cancer screening policies. If Medicare's requirements are not met, resulting in a denial, I agree to be personally and fully responsible for payment.

_____ _____

Patient Signature Date

I hereby confirm that my Medicare benefits are NOT currently replaced by any form of a "Medicare Replacement Contract." This means ***I DO NOT HAVE***:

Humana Gold Plus Plan Medicare HMO
Cigna Healthcare for Seniors Medicare Contract
Pacificare SecureHorizons Medicare HMO
Or any other Medicare HMO/PPO

Healthnet Medicare + Choice HMO
Aetna US Healthcare Golden Medicare Plan
Maricopa Senior Select Medicare HMO
AHCCCS Special Needs Plan

Therefore, in order to process my Medicare claim, I understand the claims will be sent to MEDICARE—NOT AN HMO or AHCCCS plan. **I UNDERSTAND THAT I WILL BE PERSONALLY LIABLE FOR MEDICARE CHARGES IF I AM CURRENTLY ENROLLED IN A MEDICARE or AHCCCS HMO AND HAVE FAILED TO DISCLOSE THIS INFORMATION TO AFFILIATED COLON & RECTAL SURGEONS, PC.**

_____ _____

Patient Signature Date

Financial Policy

Thank you for choosing A.C.R.S. for your care. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our office personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claim to your insurance company and make every attempt to collect the information that you provided. Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance and deductibles on the day of service**. Should an overpayment occur on the deductible or percentage amounts charges, we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled, please be aware there will be a physician, facility, anesthesia and lab fee. We only submit claims for the physician.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of service rendered if your insurance carrier does not pay, for any reason. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept Visa, MC, personal checks, or cash.

All insurance information, including prior authorization and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment, you will be rescheduled or considered self-pay. Your appointment will be delayed while you obtain the information.

Delinquent accounts will be subject to the following actions. A 35% collection-processing fee will be added to your outstanding balance and turned over to our collection agency for further processing.

There will be a $20 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, cash, Visa or MC).

There will be a $25 service fee for completing FMLA or disability paperwork. This fee applies per form.

If you need to cancel a scheduled appointment, please contact our office at least 48 hours prior to your appointment. Due to high demand for appointments, missed appointments prevent us from scheduling appropriately and caring for others in need of urgent care.

It is **your responsibility** to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the Financial Policy and I agree to abide by its terms. A copy will be provided upon patient's request.

_____

Printed Name of Patient

_____ _____

Signature of Patient / Responsible Person Date