AFFILIATED
COLON AND RECTAL SURGEONS, P.C.
Specializing in Colorectal Surgery and Colonoscopy

PERSONAL INFO

Title Dr. Miss Mr. Mrs. Ms. (select one)

Last Name _____ **First Name** _____ **MI** _____

Previous Name (if any) _____**Address** _____

City _____ **State** _____ **Zip**_____

Hm Phone (_____)_____-_____**Cell Phone** (_____)_____-_____ **Wk Phone** (_____)_____-_____

Email _____ **Primary Care Provider** _____

Referring Provider _____ **DOB (mm/dd/yyyy)** _____ / _____ / _____

Marital Status Divorced Married Partner Single Widowed Legally Separated (select one) **Sex** M F TG

Social Security _____ - _____ - _____ **Employer Name** _____

Employment Status _____ **Occupation** _____

Emergency Contact

Last Name _____ **First Name** _____

Relationship to patient: _____ **Cell Phone** (_____)_____-_____

INSURANCE

Circle any/all that apply: **MEDICARE/MEDICARE REPLACEMENT * AHCCCS * INSURANCE * SELF PAY**

Primary Insurance *Name and/or Network:* _____

Subscriber Number/Member ID _____ **Group Number** _____

Insured Name, if different than patient _____ **Insured DOB** ____ / ____ / _____

Patient Relationship to Insured _____ **Specialist Co-Pay $** _____

Secondary Insurance *Name and/or Network:* _____

Subscriber Number/Member ID _____ **Group Number** _____

Insured Name, if different than patient _____ **Insured DOB** ____ / ____ / _____

Patient Relationship to Insured _____ **Specialist Co-Pay $** _____

AMERICAN RECOVERY & REINVESTMENT ACT STATISTICAL DATA (select one)

Race Am. Indian/Alaskan Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other

Ethnicity Hispanic or Latino Not Hispanic or Latino Refuse to answer

Preferred Language English Indian (includes Hindi/Tamil) Spanish Russian or _____

*PREFERRED **RETAIL** PHARMACY*

Name _____ **Address/Location** _____

Phone Number (_____)_____-_____ **Fax Number** (_____)_____-_____

*PREFERRED **MAIL ORDER** PHARMACY*

Name _____ **Address/Location** _____

Phone Number (_____)_____-_____ **Fax Number** (_____)_____-_____

Patient Name _____

REASON FOR VISIT

_____

CURRENT MEDICATIONS

Please list all current prescription medications: ☐ None

_____

_____

Do you take aspirin, ibuprofen, or any other non-steroidal anti-inflammatories? ☐ Y ☐ N

List all current over-the counter medications and/or herbal supplements:

_____

PAST MEDICAL HISTORY

Have you been diagnosed with any of the following?

Anal cancer Y N	Deep vein thrombosis Y N	Kidney disease/stones Y N
Asthma Y N	Dementia Y N	Lactose intolerance Y N
Atrial fibrillation Y N	Depression Y N	Leukemia Y N
Bipolar disorder Y N	Diabetes mellitus Y N	Myocardial infarction Y N
Bleeding disorder Y N	Diabetes, type II Y N	Parkinson's disease Y N
Cirrhosis Y N	Epilepsy/seizures Y N	Prostate cancer Y N
Colon/rectal cancer Y N	Fibromyalgia Y N	Pulmonary embolism Y N
Colon polyps Y N	GI disease (ulcers, etc.) Y N	Stroke Y N
Congestive heart failure Y N	Hepatitis Y N	Thyroid disease Y N
COPD Y N	High blood pressure Y N	Vascular disease Y N
Coronary artery disease Y N	HIV Positive Y N	Other _____

ALLERGIES

List any drug and/or food and/or latex type allergies and your reaction to them.

_____

SURGICAL HISTORY AND ENDOSCOPIES ☐ None

Please indicate your history of **surgeries** and/or **colonoscopies**:

Procedure	Reason	Facility	Year	Physician

NON-SURGICAL HOSPITALIZATIONS ☐ None

Please indicate your history of hospitalizations for **non-surgical admissions**:

Reason/hospitalization	Facility	Year	Admitting physician

Patient Name _____

FAMILY HISTORY ☐ No relevant family history ☐ Family history unknown

Please describe any relevant GI family history. If family history exists, please indicate the approximate age at which the condition was diagnosed.

	Colon/Rectal Polyps	Colon/Rectal Cancer	Crohn's Disease	Ulcerative Colitis	Breast/GYN Cancer	Age at diagnosis
Father					n/a	
Mother						
Brother					n/a	
Sister						
Son(s)					n/a	
Daughter(s)						
Grandfather					n/a	
Grandmother						

SOCIAL HISTORY

Tobacco Use/Smoking

Please read the following questions and circle the answer which most closely describes your current situation:

Are you a: • current smoker • former smoker • nonsmoker?

How long since you last smoked? • N/A • < 1 year • 1-5 years • 5-10 years • >10 years

Are you interested in receiving information about smoking cessation? ☐ N/A ☐ Y ☐ N

Alcohol screen

Have you had a drink containing alcohol in the past year? ☐ Y ☐ N

How often did you have a drink containing alcohol in the past year?

• Never • Monthly or less • 2 to 4 times a month • 2 to 3 times a week • 4 or more times a week

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

CARDIOVASCULAR

Chest pain Y N
Shortness of breath Y N
Palpitations Y N

GASTROINTESTINAL

Abdominal pain Y N
Nausea Y N
Vomiting Y N
Constipation Y N
Diarrhea Y N
Rectal bleeding Y N
Change in bowel habits Y N

GENERAL/CONSTITUTIONAL

Weight loss Y N
Weight gain Y N
Chills Y N
Fever Y N
Change in appetite Y N

GENITOURINARY

Painful urination Y N
Difficulty urinating Y N

HEAD AND NECK

Decreased hearing Y N
Difficulty swallowing Y N

HEMATOLOGY

Easy bruising Y N

NEUROLOGIC

Difficulty speaking Y N
Loss of use of extremity Y N

PSYCHIATRIC

Change in personality Y N
Anxiety Y N
Depressed mood Y N

RESPIRATORY

Breathing difficulty Y N
Cough Y N

SURGICAL RISK ASSESSMENT

Does your current weight exceed 340 pounds? Y N
Do you have an implanted defibrillator? Y N
Do you have a pacemaker? Y N
Have you been told that you have sleep apnea (temporarily failing to breathe, while asleep)? Y N
If yes, do you HAVE a CPAP machine? Y N
If yes, do you USE your CPAP machine? Y N
Do you oppose blood transfusions for religious or other reasons? Y N
If yes, further explain **why** you would refuse an emergency transfusion, **if one was needed to save your life.**

_____

Patient Name _____

FINANCIAL POLICY:

Thank you for choosing Affiliated Colon and Rectal Surgeons, PC for your care. We welcome you! We are committed to providing the finest care, while minimizing your out-of-pocket expenses. Our financial department is dedicated to informing you, to the best of our ability, of your estimated portion of the charges for your care and assisting you with any billing questions you may have.

INSURANCE: For your convenience, we file medical claims with insurance plans with which we have an agreement, as long as valid insurance information is provided to us. It is your responsibility to make accurate and detailed insurance information is available to us to enable processing of your insurance claim. You are considered self-pay until this information is provided to us.

You are responsible for notifying our office of any insurance changes prior to scheduled appointments. Insurance policies are an agreement between you and your insurance company. All account balances are your responsibility. We collect co-pays and estimated patient co-insurance amounts during office visits. Final payment is due from the patient upon receipt of the first statement from our office.

You are expected to know your insurance benefits including deductible, co-payments and co-insurance percentages. If deductibles are not met, they are to be paid at the time of service with co-payments. If you do not have medical insurance or if Affiliated Colon and Rectal Surgeons, PC is not a participating provider with your insurance carrier, all charges incurred during treatment are due/payable at the time of service. Under certain circumstances, when the estimated amount due exceeds $500, a deposit will be required prior to the service being rendered.

All checks returned for non-sufficient funds will be assessed a $30 charge.

REFERRALS/AUTHORIZATIONS: It is your responsibility to obtain a referral from your primary care physician prior to the scheduled visit if a referral is required by insurance to obtain services provided by a specialty provider. If a referral is not obtained, the patient accepts full financial responsibility for all services rendered.

CANCELLATIONS/FEES: If you are unable to keep a scheduled appointment or procedure, it is your responsibility to notify our office 24 hours prior to the scheduled appointment or 48 hours prior to the scheduled procedure. Appointments cancelled after this timeframe may be subject to a cancellation fee**. An additional fees of $25 is applied to requests for medical records and for physicians completing paperwork for patients (i.e. disability, FMLA forms). These fees are NOT covered by insurance and are payable in advance, prior to our completion of these forms.**

SMS Consent: By providing your mobile number, you agree to receive texts from Affiliated Colon and Rectal Surgeons, P.C. for appointment reminders and office updates. Msg & data rates may apply. No medical details will be sent via SMS. Reply STOP to opt out. Consent is not required for care.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS*: I hereby authorize Affiliated Colon and Rectal Surgeons, PC to release information to my insurance company with regard to all treatment as is necessary to obtain payment for services and to review activity related to the provider's participation with my insurance plan. I assign all benefits, to which I am entitled for my treatment and medical services provided to me, to be paid directly to Affiliated Colon and Rectal Surgeons, PC. In the event that payment is made to me, I agree to submit payment in full to provider immediately. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge that I am bound to pay for services rendered, including all costs of collection and reasonable legal fees, should collection become necessary. I have read and understand this Financial Policy and, by signing, am in agreement and accept all terms and conditions described above.*

_____ _____

Signature Date

ACKNOWLEDGMENT OF NOTICE OF HIPPAA PRIVACY PRACTICES:

I hereby authorize Affiliated Colon and Rectal Surgeons, PC to release or procure all information necessary to secure the payments of benefits for treatment purposes or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a copy of this agreement shall be as valid as the original. I understand that HIPAA and privacy policies are available online and in the office. I have reviewed (or have been given the option to review) the Notice of Privacy Practices.

_____ _____

Signature Date

Patient Name _____

CONSENT TO IMPORT MEDICATION HISTORY:

I understand that ePrescribing (electronic prescriptions) will be utilized, when available. I hereby permit Affiliated Colon and Rectal Surgeons, PC to obtain an electronic history of other medications previously purchased at pharmacies. I understand that obtaining this information is a benefit of ePrescribing and may be utilized for my safety in preventing drug to drug interactions.

_____ _____

Signature Date

EMERGENCY CONTACT INFO AND CONFIDENTIAL MESSAGES CONCERNING MY MEDICAL CARE: (check all that apply)

- I authorize my physician to leave **BRIEF (ONLY)** confidential medical information on my **cell phone**.
- I authorize my physician to leave **EXTENDED** confidential medical information on my **cell phone**.
- I authorize my physician to leave **BRIEF (ONLY)** confidential medical information on my **home answering machine**.
- I authorize my physician to leave **EXTENDED** confidential medical information on my **home answering machine**.
- I authorize my physician to release health information to my **Emergency Contact**, as previously indicated.

I understand that my authorization(s) can be revoked, at any time, by my indication in writing of same.

_____ _____

Signature Date

Patient Name _____

Patient DOB _____

EASY PAY AUTHORIZATION

Our "Easy Pay" credit-card-on-file system gives you the opportunity to place a credit/debit card on file for any balance of charges not paid by your insurance or any non-covered charges, **not to exceed the deductible/co-insurance/copayment amounts.**

Upon authorization, your card will be held on file. When the correct amount is ascertained, you will be notified of the amount due. At that time, you will be given an opportunity to make payment by a different method (check, cash, money order). If, after three days, we are not informed about an alternate payment method, your card will be run.

Cardholder Complete Name: _____

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover Card

Card Number: _____ Exp. _____

Security Code (3 or 4 digits) _____ Billing Zip Code _____

Authorization to Pay:
I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I understand and accept the conditions of the "Easy Pay" plan.

_____ _____
Signature Date

(For Office Use Only)

Patient Account # _____ Date of Procedure _____

Procedure: _____ Est Pt Responsibility: _____