GENERAL OFFICE POLICY

THIS IS A LEGALLY BINDING CONTRACT SO PLEASE READ CAREFULLY BEFORE SIGNING
It is crucial that your read, understand, and accept the terms of this contract and abide by our financial policy so we can continue to serve you.

PAYMENTS: ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE. Our Practice has the responsibility to operate in a financially prudent manner to allow us to continue serving you and our community. This includes collecting amounts due prior to or at the time of rendering services. Amounts due include, and are not limited to, personal obligations such as co-pays, deductibles, coinsurance, administrative fees, and past due balances. Moreover, I agree any positive balance remaining may be applied to future visits or charges, unless otherwise requested. Acceptable forms of payment include cash, Visa, Mastercard, Discover, and American Express**. We do not accept personal checks.**

BILLING: We expect prompt payment of all balances due. Failure to do so will place your account in collection status. You will then be barred from receiving any additional services from us until your account is PAID IN FULL. Any balance assigned to a collection agency will be assessed a 40% fee to offset the recovery expense.

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 your Health Plan to see a specialist. If a referral is not obtained when required by your Health Plan, you accept full financial responsibility for all services rendered.

HEALTH PALNS: We are not contracted with or accept all Health Plans. It remains **your responsibility and yours alone** to check and fully understand your Health plan benefits before your visit. Moreover, this Practice is not necessarily obligated to file a claim on your behalf for any outpatient or inpatient procedures or visits. You acknowledge that you have had the opportunity to receive a quote for services rendered or to be rendered and agree to pay all office and any additional fees incurred during your visit(s).

INITIAL:_____

CANCELLATIONS/ RESCHEDULING FEES FOR <u>OFFICE VISITS</u>
When you do not show up for your appointment, it creates an unused appointment slot that could have been used for another patient in need for an urgent appointment. It is therefore very important that you call 24 hours in advance to cancel or reschedule your appointment. **Office visit NO SHOWS, CANCELLATIONS LESS THAN 24 HOURS from date of office visit, or late arrival of more than 15 minutes will have to be rescheduled and incur a $125 fee. This will be due before rescheduling and is not covered by insurance.**

INITIAL:_____

CANCELLATIONS/ RESCHEDULING FEES FOR <u>ENDOSCOPIC OR SURGICAL PROCEDURES</u> PROCEDURE NO SHOWS OR CANCELLATION MADE LESS THAN THREE BUSINESS DAYS WILL INCURR A $250 fee. NO EXCEPTIONS.

INITIAL:_____

Rescheduling endoscopic or surgical procedures more than 3 business days from day of procedure will incur a **$25 rescheduling fee for every occurrence**. This fee is due at the time of rescheduling and is not covered by insurance.

INITIAL:_____

MEDICAL RECORDS

When requesting copies of your medical records, please allow 48-72 business hours to process. Records must be picked up in the office and cannot be faxed or e-mailed due to privacy concerns. There are additional fees for copies of medical records and for physician completing paperwork such as Disability or FMLA forms. **These fees are NOT COVERED by insurance and are your responsibility.**

You acknowledge that you have had ample time to review, understand, and accept those terms

RELEASE OF INFORMATION: I hereby authorize this Practice to release information to my insurance company or Health Plan 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 health plan. I assign all benefits, to which the patient or insured is entitled, for my treatment and medical services provided to me, to be paid directly to the Practice or its designee. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my health plan. I acknowledge 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 I am in agreement and accept all terms and conditions described above.

I have read, understand the above office policy and agree to abide by its terms.

Patient or legally authorized individual

Name/signature:_____

Date:_____

Registration Form *ColoRectal Consultants*

PATIENT INFORMATION

Last Name:	First Name:	Middle:	Gender: M ◯ F ◯

Address:	City:	State:	Zip:

Date of Birth:

Home Phone:	Cell phone:	Work Phone:

Social Sec #:	Email:

Occupation:	Race:

Referred by:	Phone #:	Fax #:

Primary Care Physician:

INSURANCE INFORMATION

Please indicate primary insurance:

Policy Holder's name:	Patient Policy #:	Group #:	Ins Phone #:

Name of secondary insurance (if applicable):

Policy Holder's name:	Policy #:	Group #:	Ins Phone #:

PHARMACY INFORMATION

Pharmacy:

Address:	City:	State:	Zip:	Phone #:

EMERGENCY CONTACT

Name of local friend or relative:	Relationship to patient:	Home phone #:	Work phone #:

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for all charges whether or not they are paid by insurance. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If the account is not paid in full, my account(s) may be referred to a collection agency and I will be responsible for all attorney's and/or collection fees.

I authorize ColoRectal Consultants or its representatives 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 further agree that a photocopy of this agreement shall be as valid as the original.

I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request. I have read and understand the information on this form.

Patient/Guardian signature:	Print Name:	Date:

HISTORY ***ColoRectal Consultants***

First Name:	Last Name:	DOB:	Today's date:

Medical History	☐ No Medical History to Report				
Gastrointestinal	☐ GERD-reflux	☐ Stomach Ulcer	☐ Colon polyps	☐ Crohns disease	☐ Ulcerative Colitis
	☐ Diverticulosis	☐ Diverticulitis	☐ Liver cirrhosis	☐ Hepatitis	☐ Pancreatitis
Pulmonary	☐ Lung cancer	☐ COPD	☐ Asthma	☐ Valley Fever	☐ Sleep apnea
Cardiac	☐ Heart attack	☐ Angina/chest pain	☐ CHF	☐ Atrial fibrillation	☐ Hypertension
Neurologic	☐ Stroke	☐ Seizures	☐ Dementia	☐ Parkinsons	☐ Peripheral neuropathy
Urinary	☐ Kidney stones	☐ Enlarged prostate	☐ Prostate cancer	☐ Kidney failure	☐ Kidney tumor
Endocrine	☐ Hypothyroidism	☐ Hyperthyroidism	☐ Elevated cholesterol	☐ Diabetes	☐ Stroke
Musculoskeletal	☐ Fibromyalgia	☐ Arthritis	☐ Osteoporosis	☐ Carpal tunnel	☐ Bone fracture
Hematologic	☐ Anemia	☐ Leukemia	☐ Lymphoma	☐ Bleeding disorder	☐ Enlarged spleen
Psychiatric	☐ Anxiety disorder	☐ Depression	☐ ADHD/ADD	☐ Bipolar disorder	☐ Insomnia
Vascular	☐ DVT	☐ Peripheral vascular dis	☐ Pulmonary embolus	☐ Aortic aneurysm	☐ Carotid artery disease
Cancer	Type:				
Other condition(s):					

Surgical History		☐ No Surgeries to Report			
Procedure	When	Procedure	When	Procedure	When
☐ Bowel surgery		☐ Pacemaker/Defib		☐ Heart Bypass	
☐ Heart stent		☐ Aortic aneurysm		☐ Hysterectomy	
☐ Cataract surgery		☐ Arthroscopy		☐ Gall bladder surgery	
☐ Hemorhoid surgery		☐ Hemorrhoid banding		☐ Hip replacement	
☐ Knee replacement		☐ Tonsillectomy		☐ Thyroid surgery	
☐ Prostate surgery		☐ Breast surgery		☐ Heart valve	
☐ Tubal ligation		☐ Carpal tunnel		☐ C section	

If you checked any of the above, Please report reason:

Any surgical procedures not mentioned above:

COLONOSCOPY	☐ Never Had Colonoscopy	
Findings	Completed by	When

Social History	***Never***	***Quit***	***Quit When***	***Smoker***	***How much/often***
Tobacco	☐	☐		☐	
Alcohol	☐	☐		☐	
Recreational Drug(s)	☐ No	☐ Yes	Type:	Frequency:	

Allergies	
Allergy to:	Reaction:

Family History- Enter *age at diagnosis* if applicable	☐ No Known Family History									
	Colon Cancer	Colon Polyps	Ulcerative Colitis	Crohns Disease	Breast Cancer	Ovarian Cancer	Uterine Cancer	Bladder Cancer	Prostate Cancer	Other
Father										
Mother										
Brother										
Sister										
Son										
Daughter										
Grandfather										
Grandmother										
Other										

Immunizations	
☐ Flu Vaccine	When received
☐ Pneumonia Vaccine/Pneumovax	When received

MEDICATIONS ☐ No Medications

Medication Name	Strength (mg, ml)	Frequency	Reason for taking

Preferred Pharmacy			
Name			
Address			
City	State	Zip	Phone:

Review of Systems: Do you currently, or have you ever had any problems in the following areas?

Constitutional	☐ Weight gain	☐ Weight loss	☐ Night sweats	☐ Fatigue	☐ Fever
Integumentary	☐ Itchiness	☐ Rash	☐ Excessive dryness	☐ Tumors	☐ Moles
Eyes	☐ Visual change	☐ Eye pain	☐ Double vision	☐ Blind spots	☐ Floaters
ENT	☐ Runny nose	☐ Nose bleeds	☐ Sinus pain	☐ Ringing in ears	☐ Ear pain
	☐ Painful swallowing	☐ Sore throat	☐ Dental problems	☐ Gingival bleeding	☐ Decreased hearing
Respiratory	☐ Cough	☐ Excessive sputum	☐ Wheezing	☐ Shortness of breath	☐ Bloody sputum
Cardiovascular	☐ Chest pain	☐ Palpitations	☐ Irregular Heartbeat	☐ Claudication	☐ Leg swelling
Gastrointestinal	☐ Decreased appetite	☐ Abdominal pain	☐ Change in bowel habits	☐ Constipation	☐ Diarrhea
	☐ Bright red rectal blood	☐ Black tarry stool	☐ Bloody diarrhea	☐ Cramping	☐ Bloating
	☐ Food avoidance	☐ Nausea/Vomiting	☐ Vomiting blood	☐ Inability to pass gas	☐ Incomplete evacuation
Urinary	☐ Frequent urination	☐ Burning urination	☐ Blood in urine	☐ Urinary incontinence	☐ Decreased force of stream
Genital	☐ Vaginal discharge	☐ Abnormal menses	☐ Menopause	☐ Erectile dysfunction	☐ Pelvic/testicular pain
Musculoskeletal	☐ Joint pain/swelling	☐ Pain in muscles	☐ Morning stiffness	☐ Limited range of motion	
Neurologic	☐ Weakness	☐ Numbness	☐ Pins and needles	☐ Peripheral neuropathy	☐ Poor balance
	☐ Headaches	☐ Tremors	☐ Seizures	☐ Speech difficulties	
Psychiatric	☐ Depression	☐ Anxiety	☐ Sleep disturbance	☐ Change in thought content	

NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Ace of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information. We may use and disclose your medical records only for each of the follow purpose: treatment, payment, and health care operations:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide reminders or information about treatment or other health-related benefits and services that may be of interest to you. Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notices of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice, or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Patient Signature: _____

For more information about HIPAA, or to file a complaint, please contact:
The U.S. Department of Health and Human Services, Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C., 20201 | (202) 619-0257 | Toll Free: 1-877-696-6775

Consent to Receive Text Message Appointment Reminders

By signing below, I authorize ColoRectal Consultants and its affiliates to contact me by automated SMS text message and/or e-mail for appointment reminders.

I understand that message/data rates may apply to messages sent under my cell phone plan.

My text/mobile phone number is: ( )

My email is : _____

I know that I am under no obligation to authorize ColoRectal Consultants or its affiliates to send me text messages or emails. I may opt-out of receiving these communications at any time by calling the Service Desk @ (480) 240-7391. Please allow 2-3 days for processing.

I understand that text messaging/email are not secure formats of communication.

There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages/emails via automated technology from Colorectal Consultants and its affiliates to the phone number/email that I have provided.

Patient Name: _____

Signature: _____

Date: _____Date of Birth: _____

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Medical Information	Billing information
Dr._____	_____
Dr._____	_____
Spouse _____	_____
Other_____	_____

I understand that:

I may inspect or copy the protected health information to be used or disclosed.

I may revoke this authorization in writing by contacting your office.

Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization.

Patient Name:_____

Signature:_____ Date:_____

CLICK HERE TO PRINT FORM

AFTER PRINTING, PLEASE SIGN SIGNATURE FIELDS ON ALL PAGES AND BRING COMPLETED FORM TO YOUR APPOINTMENT