GULFCOAST GASTROENTEROLOGY CONSULTANTS

Diplomates American Board of Gastroenterology and Internal Medicine

Joseph M. Daly, M.D.
Alan R. Klibanoff, M.D.
Richard G. LaCamera, M.D.

Michael W. Peebles, M.D.
Eric A. Steckler, M.D.
Laurence H. Zeitlin, M.D.

PLEASE COMPLETE ALL PAGES AND BRING THE FORMS WITH YOU TO YOUR APPOINTMENT

PLEASE DO NOT MAIL

VERY IMPORTANT PLEASE READ

IF THE PURPOSE OF YOUR OFFICE VISIT IS TO BE SEEN PRIOR TO A "SCREENING" PROCEDURE, PLEASE NOTE, THAT MEDICARE, SOME HMO'S, PPO'S AND PRIVATE INSURANCES, MAY NOT COVER THIS VISIT.

MEDICARE WILL PAY FOR "SCREENING" COLONOSCOPY, PROVIDED YOU HAVE NOT HAD ONE WITHIN 10 YEARS OR A SCREENING FLEXIBLE SIGMOIDOSCOPY WITHIN FOUR YEARS. HOWEVER, MANY HMO'S, PPO'S, AND PRIVATE INSURANCES MAY NOT PAY FOR A STRICTLY "SCREENING" COLONOSCOPY. IF YOUR INSURANCE COMPANY DOES NOT PROVIDE US WITH PAYMENT FOR THESE SERVICES, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

PLEASE NOTE THAT IF YOU HAVE SYMPTOMS THAT MIGHT BE FROM COLON PROBLEMS, PREVIOUS HISTORY OF COLON POLYPS, COLON CANCER, CROHNS DISEASE, ULCERATIVE COLITIS OR A STRONG FAMILY HISTORY OF COLON CANCER, MOST INSURANCE COMPANIES WILL PAY FOR COLONOSCOPIES AT APPROPRIATE INTERVALS.

IT IS SUGGESTED THAT IF YOU HAVE ANY QUESTIONS REGARDING SERVICES NOT COVERED BY YOUR INSURANCE PLAN, THAT YOU CALL YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT.

EVEN THOUGH SOME INSURANCE COMPANIES MAY NOT PAY FOR SUCH SERVICES, IT IS STILL HIGHLY RECOMMENDED THAT SUCH PROCEDURES BE DONE.

PLEASE SIGN THAT YOU HAVE READ AND UNDERSTAND THE ABOVE.

SIGNATURE _____ **DATE** _____

33920 U.S. 19 N. • Suite 124 • Palm Harbor, FL 34684 • (727) 785-7654 • Fax (727) 787-0061
2044 Trinity Oaks Blvd. • Suite 120 • New Port Richey, FL 34655 • (727) 372-1001 • Fax (727) 787-0061

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Financial Agreement

You are responsible, as the insured and the patient, for being sure that we have your correct insurance information on file. We will ask to see your insurance card(s) at each visit. If you do not inform us of changes, or provide us with incorrect information you will be responsible for the charges incurred for office visits and any procedures that may be scheduled on your behalf.

Payments are due at the time of service, unless payment arrangements have been made prior to your appointment. We accept cash, checks, money orders, credit cards (Mastercard, Visa, and Discover). Any returned check will have an additional $25.00 charge to the original amount of the check. The full amount is due within 10 days of the returned check.

MEDICARE: We do accept assignment on all COVERED charges by Medicare, and will file charges to them. We will file ONE subsequent insurance policy for office visits, procedures or hospitalizations. If you do not have a secondary insurance, you will be responsible for the 20% Medicare does not pay for, at the time of your office visit.

HMO's AND PPO'S: If we are a participating provider with your insurance company, we are responsible to file your claim. You, as the insured, are responsible for any co-payment, deductible, co-insurance, or payment for any non-covered service. If you have a co-payment for office visits, you will be responsible to pay that amount at the time of your office visit. If your insurance plan requires a REFERRAL OR AUTHORIZATION, it is YOUR responsibility to make sure that it is in our office PRIOR to your office visit. We suggest you contact your primary care physician at least 2 weeks before your appointment. If for some reason you do not have a REFERRAL OR AUTHORIZATION at the time of your appointment, we will either need to reschedule your appointment or you may pay for the visit in full, prior to leaving our office. However, without an authorization for the office, we will be unable to schedule any subsequent procedures you may need to have done.

PRIVATE AND INDEMNITY PLANS: We DO NOT accept assignment on your claims. You will be responsible to pay for your office visit in full at the time of service. We will file your claim to your insurance company, as a courtesy to you. It is up to you to be sure that your insurance company reimburses you for your payment. If you are scheduled for a procedure we will file your claim and you will be billed later for any balance remaining after your insurance company makes their payment. IF YOUR INSURANCE COMPANY DOES NOT REIMBURSE YOU THE FULL AMOUNT OR PAY FOR ANY PROCEDURE IN FULL, DUE TO WHAT THEY CONSIDER "REASONABLE AND CUSTOMARY", THAT IS BETWEEN YOU AND YOUR INSURNCE COMPANY.

In order to accommodate those patients in need of an appointment and respect for those who honor their existing ones, we ask that you provide us with at least 48 hours notice if you need to cancel or reschedule. Failure to do so may result in a cancellation fee. Thank you.

_____ _____

PATIENT SIGNATURE **DATE**

If you have any questions regarding this agreement please do not hesitate to ask. Thank you.

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

GULFCOAST GASTROENTEROLOGY CONSULTANTS

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PATIENT INFORMATION

PATIENT'S NAME _____
LAST FIRST MI

PATIENT'S ADDRESS _____
CITY STATE ZIP

NORTHERN ADDRESS _____

PATIENT'S HOME PHONE # _____ CELL PHONE # _____ M F

SOCIAL SECURITY # _____ DATE OF BIRTH _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

EMPLOYER _____ WORK PHONE _____

PRIMARY CARE PHYSICIAN _____

EMERGENCY CONTACT _____ PHONE NUMBER _____ RELATIONSHIP _____

PRIMARY INSURANCE _____

POLICY # _____ GROUP # _____

POLICYHOLDER NAME _____ POLICYHOLDER DOB _____

POLICYHOLDER SS # _____ POLICYHOLDER EMPLOYER _____

INSURANCE ADDRESS _____
CITY STATE ZIP

SECONDARY INSURANCE _____

POLICY # _____ GROUP # _____

I authorize the release of any medical information necessary to process this claim. I also request that payment of Government Benefits be paid to Gulfcoast Gastroenterology Consultants. The PHI (Personal Health Information) contained is **HIGHLY CONFIDENTIAL**. It is to be used only to aid in providing specific healthcare services to this paitent. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.

Also, I request that payment of authorized Medical or Medigap (if Medicare) benefits be made on my behalf to Gulfcoast Gastroenterology Associates for any services furnished me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand and agree, regardless of my insurance, I am ultimately and fully responsible for my account for any professional services rendered. I also agree to pay all collection, attorney and court fees that may be incurred for the collection of delinquent accounts.

SIGNATURE _____ DATE _____

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GULFCOAST GASTROENTEROLOGY CONSULTANTS

Diplomates American Board of Gastroenterology and Internal Medicine

Please Print DATE _____

NAME _____ PHONE _____ AGE _____

ADDRESS _____

Personal Physician _____ Address _____

Referring Physician _____ Address _____

PLEASE LIST YOUR CURRENT SYMPTOMS AND MEDICAL PROBLEMS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

HAVE YOU EVER HAD:

REG. MEASLES	NO	YES	GER. MEASLES	NO	YES	MUMPS	NO	YES
WHOOPING COUGH	NO	YES	DIPHTHERIA	NO	YES	CHICKEN POX	NO	YES
SMALL POX	NO	YES	SYPHILLIS	NO	YES	GONORRHEA	NO	YES
TYPHOID FEVER	NO	YES	INFLUENZA	NO	YES	PNEUMONIA	NO	YES
TUBERCULOSIS	NO	YES	SCARLET FEVER	NO	YES	RHEUMATIC FEVER	NO	YES
STREP THROAT	NO	YES	POLIO	NO	YES	MENINGITIS	NO	YES

PLEASE LIST ALL OF YOUR HOSPITALIZATIONS IN CHRONOLOGICAL ORDER:

	DATE	HOSPITAL	PROBLEM		DATE	HOSPITAL	PROBLEM
1.				4.			
2.				5.			
3.				6.			

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITIONS OR ILLNESSES:

1. _____
2. _____
3. _____
4. _____

ANY INJURIES:

1. _____
2. _____
3. _____
4. _____

MEDICATIONS: LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES:

PENICILLIN	NO	YES	OTHER DRUGS	_____
SULFA DRUGS	NO	YES		_____
BARBITURATES	NO	YES		_____
EGGS	NO	YES		_____

PERSONAL HISTORY:

PLACE OF BIRTH _____ CIGARETTES, PACKS PER/DAY _____ CIGARS ☐ PIPE ☐

STATES IN WHICH YOU HAVE LIVED _____ ALCOHOL CONSUMPTION _____

COUNTRIES WHERE YOU LIVED OR VISITED _____ TYPE _____ QUANT. PER WEEK _____

CURRENT OCCUPATION _____ COFFEE, CUPS PER DAY _____ TEA, CUPS PER DAY _____

PREVIOUS OCCUPATION _____ REGULAR EXERCISE ☐ YES ☐ NO TYPE _____

PLEASE TURN OVER AND COMPLETE BACK PAGE

NAME _____ DATE _____

FAMILY HISTORY		AGE	IF LIVING, HEALTH	AGE AT DEATH	IF DECEASED, CAUSE	RECORD THE APPROXIMATE DATE YOU LAST HAD ANY OF THE FOLLOWING:	DATE HAD
FATHER						COMPLETE MEDICAL EXAM	
MOTHER						WOMEN – PAP SMEAR	
☐ BROTHER ☐ SISTER	1.					CHEST X-RAY	
☐ BROTHER ☐ SISTER	2.					TEST STOOL FOR BLOOD	
☐ BROTHER ☐ SISTER	3.					PROCTO	
☐ BROTHER ☐ SISTER	4.					EKG	
☐ BROTHER ☐ SISTER	5.						
HUSBAND OR WIFE							
☐ SON ☐ DAUGHTER	1.						
☐ SON ☐ DAUGHTER	2.						
☐ SON ☐ DAUGHTER	3.						
☐ SON ☐ DAUGHTER	4.						

SYSTEMS REVIEW: Have you had any of the following problems within the past 3 months?

H.	FREQUENT HEADACHES	NO	YES
	MIGRAINE HEADACHES	NO	YES
E.	DOUBLE VISION	NO	YES
	BLURRED VISION	NO	YES
	SPOTS BEFORE EYES	NO	YES
	BLINDNESS	NO	YES
	EYE PAIN	NO	YES
	GLAUCOMA	NO	YES
	NEED FOR GLASSES	NO	YES
E.	EAR INFECTION	NO	YES
	RINGING IN EARS	NO	YES
N.	NOSE BLEEDS	NO	YES
	DISCHARGE	NO	YES
	LOSS OF SMELL	NO	YES
	FREQUENT COLDS	NO	YES
	POST NASAL DRIP	NO	YES
T.	FREQUENT SORE THROAT	NO	YES
	CHRONIC HOARSENESS	NO	YES
	STREP THROAT	NO	YES
PULM.	CHRONIC COUGH	NO	YES
	COUGHING BLOOD	NO	YES
	SPUTUM PRODUCTION	NO	YES
	SHORTNESS OF BREATH	NO	YES
	ASTHMA	NO	YES
CV.	CHEST PAIN	NO	YES
	HEART ATTACK	NO	YES
	PALPITATIONS	NO	YES
	CALF PAIN	NO	YES
	HEART MURMUR	NO	YES
	HIGH BLOOD PRESSURE	NO	YES
	LOW BLOOD PRESSURE	NO	YES
	FAINTING SPELLS	NO	YES
GI.	PEPTIC ULCER DISEASE	NO	YES
	RECUR. ABDOMINAL PAIN	NO	YES
	BLACK OR BLOODY STOOLS	NO	YES
	VOMITING BLOOD	NO	YES
	VOMITING	NO	YES
	CHANGE IN BOWEL HABITS	NO	YES
	CHANGE IN STOOL APPEAR	NO	YES
	CONSTIPATION	NO	YES
	DIARRHEA	NO	YES
	INTEST. PARASITES (worms)	NO	YES
	DIFFICULTY SWALLOWING	NO	YES
	FREQUENT HEART BURN	NO	YES
	HIATUS (HIATAL) HERNIA	NO	YES
	GALLSTONES	NO	YES
	HEPATITIS	NO	YES
	JAUNDICE (Yel. Jaundice)	NO	YES
	CIRRHOSIS OF LIVER	NO	YES
G.U.	KIDNEY/BLADDER INFEC.	NO	YES
	PAIN OR BURN. URINATION	NO	YES
	PUS IN URINE	NO	YES
	BLOOD IN URINE	NO	YES
	URINARY FREQUENCY	NO	YES
	URINARY URGENCY	NO	YES
	URINATING AFTER BEDTIME	NO	YES
	URINARY DRIBBILING	NO	YES
	KIDNEY/BLADDER STONES	NO	YES
ENDO.	RECENT WT. GAIN	NO	YES
	EXCESSIVE SWEATING	NO	YES
	DIABETES (sugar in urine)	NO	YES
	HIGH CHOLESTEROL	NO	YES
N.P.	STROKE	NO	YES
	PARALYSIS OR WEAKNESS	NO	YES
	LOSS OF SENSATION	NO	YES
	SPEECH ABNORMALITY	NO	YES
	CONVULSION	NO	YES
	LOSS OF BALANCE	NO	YES
	DEPRESSION	NO	YES
	CONFUSION	NO	YES
	CRYING SPELLS	NO	YES
	NERVOUS BREAKDOWN	NO	YES
MS	JOINT PAINS	NO	YES
	TENDER, SWOLLEN, RED OR HOT JOINTS	NO	YES
	BACK PAIN	NO	YES
	FREQUENT LEG CRAMPS	NO	YES
HEM	ANEMIA	NO	YES
	TREATMENT.....DATE.....		
	BLOOD TRANSFUSION	NO	YES
	WHEN .....WHY .....# UNITS.....		
	EXCESSIVE BLEEDING	NO	YES
	RECURRENT NOSE BLEEDS	NO	YES
	EASY BRUISABILITY	NO	YES
ONC.	LOSS OF APPETITE	NO	YES
	UNEXPLAINED WT. LOSS	NO	YES
	ANY LUMP OR MASS	NO	YES
	REMOVED.....WHEN.....		
	UNUSUAL MOLE OR WART	NO	YES
	ENLARGED LYMPH NODES	NO	YES
	MALE ONLY		
	PROSTATE TROUBLE	NO	YES
	DIF. INITIATING STREAM	NO	YES
	INTERRUPTED STREAM	NO	YES
	IMPOTENCE	NO	YES
	FEMALE ONLY		
	DATE OF LAST PERIOD.....		
	DURATION OF PERIOD .....DAYS		
	LENGTH OF CYCLE .....DAYS		
	NO. OF PREGNANCIES.....		
	EX. FLOW DURING PERIODS	NO	YES
	BLEED. BETWEEN PERIODS	NO	YES

SIGNATURE _____

REORDER # 07-05785-30

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MEDICARE ONLY

(A) Notifier(s):

(B) Patient Name: (C) Medicare Identification Number:

Advanced Beneficiary Notice of Noncoverage (ABN)

NOTE: if Medicare doesn't pay for procedure below you may have to pay.

Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the procedure below.

Procedure	Reason the Medicare may not pay	Estimated Cost:
Colonoscopy	Medicare pays for a screening colonoscopy one time every 10 years. If patient has a family history of colon cancer or any colon disease, Medicare allows colonoscopy more frequently.	

What you need to do now:
• Read this notice, so you can make an informed decision about your care.
• Ask us any questions that you may have after you finish reading.
• Choose an option below about whether to receive the colonoscopy listed above.
Note: if you choose option one or two we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **Option 1**. I want the colonoscopy listed above. You may ask to be paid now, but I also want Medicare billed for the official decision on payment, which is said to me on a Medicare \Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. That Medicare does pay; you will refund any payments I made to you, less co-pays or deductibles.

☐ **Option 2**. I want the colonoscopy listed above, but do not bill Medicare. You may be asked to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **Option 3.** I don't want the colonoscopy listed above. I understand with this choice I'm not responsible for payment and **I cannot appeal to see if Medicare would pay.**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048)

Signing below means that you have received and understand this notice. You will also receive a copy.

Signature:_____ Date:_____

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Any Other Insurer than Medicare

Advanced Beneficiary Notice of Noncoverage (ABN)

Note: The purpose of this form is to help you make an informed decision about whether or not you elect to receive the following services. Your insurance company only pays for **COVERED** services, as stated by your insurance company. We are informing you that your insurance company **MAY NOT** pay for: **SCREENING COLONOSCOPY**

Please read carefully:

We suggest you contact your insurance company with any questions you may have regarding your benefits for this procedure. If you contact them, you may need the following information: procedure code 45378 and diagnosis code V76.51. These codes are exactly how we bill them to your insurance, provided it is strictly as "screening" procedure. However, when the Doctor performs the procedure, the diagnosis will be billed according to the findings (i.e., Polyps) regardless of the original reason for the procedure. Many insurance companies are now offering screening colonoscopy at 100%*HOWEVER*** if anything is found on your colonoscopy (polyps, etc.), your insurance company most likely WILL NOT pay at 100% and will apply this to your regular medical benefits. This would include deductible, coinsurance, out of pocket, and copays. It would be FRAUDULENT to bill the procedure as screening if polyp's or any other pathology are found.**

The fact that your insurance company may not cover this procedure does not mean you should not have this done. There is a valid reason your Doctor recommended this procedure.

_____ _____

(Patient Signature) (Date)

_____ _____

(Patient's printed name) (Account #)

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