

Notice to all HMO and PPO patients:

Your HMO or PPO health insurance plan has specific rules you must follow in order for you to avoid liability for full payment on services rendered.

We participate with many HMO and PPO plans. It is your responsibility as a patient to provide us with an updated authorization/referral on the day of your scheduled appointment.

Our office cannot be held responsible for obtaining authorizations/referrals. If we do not have an authorization on file on the date of your scheduled appointment, our appointment schedulers will reschedule you for a later date.

To avoid this problem, we suggest you contact your primary care physician in advance. This will allow them sufficient time to provide you with an authorization.

We believe you should know the following information about your plan:

- 1. What does your insurance plan cover or not cover?**
- 2. Must you present a referral/authorization for each office visit?**
- 3. What is your payment (co-payment/deductible) responsibility for each visit?**
- 4. Which hospitals have a contract with your plan?**
- 5. Is the physician you are seeing fully covered by your plan?**
- 6. Which clinical laboratory is covered by your insurance (Quest or Labcorp)?**

You are responsible for co-payments and deductibles on the day that services are rendered. Our office accepts cash, checks, Master Card, Visa, and American Express for your convenience.

Finally, this is your insurance plan. Please familiarize yourself with every rule of the health plan you are enrolled in. Knowing this information can save you substantial amounts of money. Your insurance company will mail a summary of charges, payments, denials, or requests for further information. Please review all insurance correspondence.



Gastroenterology
Care Center

7500 SW 87th Avenue, Suite 200, Miami, FL 33173 – 305-913-0666 Fax 305-913-0663 www.gicarecenter.com

**CONSENT FOR PURPOSES OF
TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

I hereby consent to the use or disclosure of my protected health information by Gastroenterology Care Center, Inc. (the "Provider") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Provider. I understand that diagnosis or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Provider is not required to agree to the restrictions that I may request. However, if the Provider agrees to a restriction that I request, the restriction is binding on the Provider and all physicians associated with the Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent the Provider has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Provider's Notice of Privacy Practices prior to signing this document. The Provider's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the the Provider. The Notice of Privacy Practices for the Provider is also provided in the waiting room. This Notice of Privacy Practices also describes my rights and the Provider's duties with respect to my protected health information.

The Provider and all physicians associated with the Provider reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

**NOTICE OF PRIVACY PRACTICES
NOTICE AND ACKNOWLEDGEMENT**

Acknowledgement:

I acknowledge that I have received Gastroenterology Care Center, Inc.'s Notice of Privacy Practices.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority



GASTROENTEROLOGY CARE CENTER

MEDICAL & FAMILY HISTORY FORM

NAME: _____ TODAY'S DATE: _____

CHART NO. _____ DATE OF BIRTH: _____

REASON FOR VISIT _____

Allergies:

NONE Aspirin Demerol Iodine Morphine Penicillin Sulfa Versed Valium Other _____

Past or Present Medical Problems

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Milk intolerance | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ear infections | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Chronic anxiety | <input type="checkbox"/> Fatty liver | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Stomach/duodenal ulcer |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Frequent urinary infections | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Stroke or paralysis |
| <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Iritis | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Cirrhosis of liver | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> TB skin test positive |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney disease/failure | <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Groin hernia | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Reflux | <input type="checkbox"/> Ulcerative colitis |

Surgeries/Hospitalization/Procedures:

- | | | | | | |
|--|--------------------------------------|--|--|---|---------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Groin Hernia | <input type="checkbox"/> Kidney | <input type="checkbox"/> Stomach | Other _____ |
| <input type="checkbox"/> Breast | <input type="checkbox"/> C-section | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Thyroid | _____ |
| <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> EGD | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Obesity Surgery | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Colon Resection | <input type="checkbox"/> ERCP | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Ovary | <input type="checkbox"/> Tubal Ligation | _____ |

Social History Marital Status:

- Single Separated Married
 Divorced Widowed

Social History Recreational Drugs:

- I have never used recreational drugs I am currently using recreational drugs
 I have used recreational drugs in the past I have been treated for substance abuse

Social History Alcohol:

- Never More than 2 days/week
 Rarely Less than 2 days/week
 Daily I quit using alcohol

Social History Tobacco:

- I use tobacco products I have never used tobacco products
 I quit using tobacco products

Social History Occupation:

Patient Occupation _____ Veteran

Social History Hobbies:

Patient Hobbies _____

REVIEW OF SYSTEMS

Gastrointestinal:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Fat intolerance | <input type="checkbox"/> Nausea, vomiting | <input type="checkbox"/> Trouble swallowing |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Poor appetite | Other _____ |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rectal bleeding | _____ |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Soiling/Incontinence | _____ |

Genitourinary:

- NONE
 Blood in urine
 Change in urinary frequency
 Sexual difficulty
 Other _____

MALE

- Prostate problem
 Testicle problem

FEMALE

- Heavy periods

Skin:

- NONE
 Nodules
 Rash
 Tattoos
 Itching
 Recurrent boils
 Skin infection
 Other _____

Cardiovascular:

- | | | |
|---|---|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Enlarged heart | <input type="checkbox"/> Swelling in the legs |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Pain in legs w/walking | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Angina/chest pain w/activity | <input type="checkbox"/> Shortness of breath | Other _____ |

Neurological:

- NONE
- Chronic numbness/tingling
- Dizziness/lightheadedness

- Headaches
- Weakness in arms
- Weakness in legs
- Other _____

Endocrine:

- NONE
- Abnormal growth/loss of hair
- Abnormally hot or cold
- Breast enlargement or pain

- Excessive thirst
- Goiter
- Hot Flashes
- Other _____

Constitutional:

- NONE
- Chills
- Fatigue
- Fever
- Night sweats

- Poor appetite
- Sweats
- Weight gain
- Weight loss
- Weight stable
- Other _____

Psychiatric:

- NONE
- Abnormal sleep
- Anxiety

- Emotional problems
- Memory loss/confusion
- Nervous breakdown
- Other _____

Eyes:

- NONE
- Blindness
- Change in vision

- Inflammation
- Poor vision
- Other _____

Hematologic:

- NONE
- Bleeding doesn't stop easily
- Enlarged glands

- Frequent bruising
- Thrombosis/blood clots
- Transfusion
- Other _____

Ears, Nose and Throat:

- NONE
- Bleeding gums
- Hearing loss
- Hoarseness

- Mouth sores
- Nose bleeds
- Ringing in ear
- Other _____

Musculoskeletal:

- NONE
- Back pain
- Broken bones

- Chronic stiff joints _____
- Disc problem
- Swollen joints
- Other _____

Respiratory:

- NONE
- Chronic cough

- Cough up blood
- Other _____

Immunizations:

- NONE
- Flu
- Hepatitis A

- Hepatitis B
- Other _____

Medications:

- NONE
- Aciphex
- Analpram
- Anusol
- Asacol
- Axid
- Bentyl
- Carafate
- Donnatal
- Lactulose
- Levbid
- Levsin
- Lomotil
- Nexium
- NuLev

- Pentasa
- Pepcid
- Prednisone
- Prevacid
- Prilosec
- Protonix
- Questran
- Rowasa
- Tagamet
- Zantac

Other _____

Current Medications**Please list any prescription or over the counter medications you are currently taking on the lines below:**

Family History:

	Father	Mother	Brother	Sister	Grandparents
Alcoholism or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>