Hernando Gastroenterology Associates

Ramakrishna P. Kanuri, M.D.
Arlene Bradford APRN, Stacey Azzolino PA
Diplomate American Board of Internal Medicine and Gastroenterology

"Competent care with compassion"

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial_____

Male___ Female ___ Date of Birth: _____ Marital Status: Single Married Divorced Widow (circle one)

Race _____Ethnicity_____Preferred Language_____

Address: _____City_____ State ___ Zip _____

Home Phone: _____ Mobile Phone: _____ Social Security# _____

Pharmacy Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Place of Employment: _____ Phone: _____

Primary Insurance _____ Policy # _____Copay_____

Secondary Insurance_____ Policy #_____Copay_____

Email address: _____@_____

Nearest Relative or Person we may contact in case of an Emergency

Name: _____ Relationship_____

Address: _____ Telephone #: _____

Assignment of Benefits Authorization for Treatment:
I hereby authorize treatment and authorize direct payment of surgical/medical benefits to Hernando Gastroenterology Associates for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

PRINT PATIENT NAME: _____
SIGNATURE: _____ DATE: _____

12190 Cortez Blvd, Brooksville, FL 34613 (352)597-1206 Fax (352-597-1208

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files are stored in our Electronic Medical Records System. These records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
10. I understand my medical care may require a physical exam and by signing I give my consent to any and all medically appropriate examinations (that may include a rectal exam) now and any future visits.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

(PRINT NAME) _____ **Date**_____

(SIGNATURE) _____

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Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

I, _____, authorize **Hernando Gastroenterology Associates**

to release and obtain my private health information to/from (check all that applies):

Name_____Relationship_____

Name_____Relationship_____

Are there any restrictions on (PHI) Protected Health Information to be disclosed: ____Yes ____ No If yes:
_____

_____No one other than myself may have access to my medical records

May our office leave a message on your machine: ____ Yes ____ No PHONE NUMBER_____

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am patient of **Hernando Gastroenterology Associates.**

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Privacy Officer at 12190 Cortez Blvd, Brooksville, FL 34613. I understand that my revocation will not affect any actions taken Hernando Gastroenterology Associates prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed, or until revoked in writing. At which time this authorization to obtain and release this protected health information expires.

_____ _____

Patient Signature or Authorized Representative and relationship Date

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FINANCIAL POLICY

The doctors and staff at Hernando Gastroenterology Associates would like to welcome you to our Practice. We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible.

By signing below, you confirm that you have read this policy and understand that;

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current – accordingly, all self-pay or insurance co-payments, co-insurance and deductibles will be collected at time of service. Payable by cash, check, Visa, MasterCard, Discover or American Express.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- There is a $40.00 charge if you do not show up for your scheduled appointment or cancel with less than 24HR notice.
- A return check will result in a $45.00 service charge **and** all future payments being required in the form of cash or credit card.
- We participate with many insurance carriers. It is important for you to verify and understand your coverage policy. Your contract is between (you) the subscriber and the insurance company; therefore, you are responsible for all charges until paid in full._____(Initial)
- Our patient statements are sent out on a monthly basis and prompt payment is expected upon receipt of your bill.
- Any unpaid balances older than 30 days may be subject to 1.5% interest per month.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE:

We will submit your claims, however ***we must emphasize that as medical providers, our relationship is with you, not your insurance company.*** Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date of service are rendered.
- We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information please do not hesitate to ask us. We are here to help you.

PRIVACY NOTICE

I understand and have available to me The Privacy Act Notice, I understand the policies in the Privacy Act Notice are subject to change and I may request an updated copy. If you do not understand any of the above policies, or you have an extenuating circumstance, please feel free to ask for our assistance.

I have read and understand the Policies and Privacy Act Notice and will comply with the above.

Patient Name (Please Print)	Patient Signature	Date
Responsible Party (Please Print) (If other than patient)	Responsible Party Signature	Date

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Patient History

Have you ever had?	No	Yes		No	Yes	Are you experiencing?	No	Yes
Hypertension			Hepatitis			Chills		
Chest pain			Diabetes			Fever		
Heart Attack			Anemia			Shortness of Breath		
Irregular Heartbeat			Gout			Epilepsy		
Pacemaker			Thyroid Disease			Numbness		
Glaucoma			Phlebitis			Extremity weakness		
Asthma			Stroke			GI Disorder		
COPD/Emphysema			Cancer			Ulcer		
Liver Disease			High cholesterol			Mental Illness		
Kidney Disease			Heart Disease			Bleeding Disorder		
Hemorrhoids			Rectal Itch			Rectal Bleeding/Pain		

Hernando Gastroenterology Associates has moved to Electronic Medical Records (EMR). In order to comply with "meaningful use", we are asking our patients to fill out the following questionnaire.

Race: Check One

	American Indian		Alaskan Native		Asian
	African American		White		Native Hawaiian/Pacific Islander
	Decline to report/Unreported				

Ethnicity: Check one

	Hispanic/Latino		Non Hispanic/Latino		Decline to report/Unreported

Nationality_____ **Decline to Report**_____

Primary Language_____ **Decline to Report**_____

Social History	Current	Past	How Much?
Alcohol			
Illegal Drug Use			

Please Check Correct Box

Tobacco Caffeine	Every day Smoker_____ Cups Daily_____	Some day Smoker_____ Cups_____	Former Smoker_____ Cups_____	Never Smoked_____ Cups_____

Patient Signature: _____ Date: _____

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MEDICATION LIST

Patient Name: _____ Date: _____

Medication Name	Strength	How taken
Surgeries & Date:	**Height:**	**Allergies:**
	Weight:	

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