GASTROENTEROLOGY ASSOCIATES
OF FLORIDA

WWW.FLAGASTRO.COM

DATE:_____ PRIMARY LANGUAGE SPOKEN:_____

PATIENT NAME: _____

DATE OF BIRTH: _____ CHECK ONE: SEX: M____ F____

CHECK ONE: MARRIED ____ SINGLE____ WIDOWED____ DIVORCED____ PARTNER ____

RACE: _____ ETHNICITY: _____

ADVANCED DIRECTIVES: Do Not Intubate Do Not Resuscitate Living Will No Advanced Directives

RESPONSIBLE PARTY:_____ RELATIONSHIP:_____ PHONE #: _____

LOCAL ADDRESS: _____

PERMANENT ADDRESS (IF DIFFERENT): _____

HOME PHONE:(____)_____ CELL: (____) _____ EMAIL: _____

EMPLOYED BY: _____ WORK #:(____) _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) _____

PRIMARY PHARMACY: _____ PHONE #: (____) _____ LOCATION:_____

PREFERRED LAB: QUEST LABCORP Other:_____

**PRIMARY CARE PHYSICIAN:** _____ PHONE #: (_____

**REFERRED BY:** _____ REASON FOR VISIT:_____

THOMAS I. ROSENFIELD, M.D.
SETH S. STEINBERG, M.D.
TODD SIMON, D.O.
LYLE K. HURWITZ, M.D.

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# Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

SIGNED: _____ DATE: _____

PRINT: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

**********

*For Office Use Only:*

- ☐ Signed form receive by: _____
- ☐ Acknowledgment refused: _____

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

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# Confidential Channel Communication Request

*As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask why you are making your request and will try to accommodate all reasonable requests.*

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment of treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

*Please select all that apply:*

**Phone:** I want you to contact me by telephone at _____

____ **Do** ____ **Do not** leave messages on my answering machine.

____ **Do** ____ **Do not** leave messages with any other person.

☐ **Mail:** I want you to contact me at the following address:

_____

_____

☐ **Email:** I want you to contact me at the following e-mail address: _____

☐ **Fax:** I want you to contact me at the following fax number: _____

☐ **Other requests for confidential communications:** You may designate a representative that is permitted to discuss your medical condition with Gastroenterology Associates of Florida on our behalf (specify):

| Name | Relation | Contact Telephone # |
|---|---|---|
| Name | Relation | Contact Telephone # |
| Name | Relation | Contact Telephone # |

Signed: _____ Print: _____ Date: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient
☐ Other (specify)

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# AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO GASTROENTEROLOGY ASSOCIATES OF FLORIDA & CONSENT FOR TREATMENT

I hereby authorize Gastroenterology Associates of Florida and its employees and agents to release my medical records documenting my examination and treatment, including AIDS related testing, psychiatric or substance abuse information, upon valid request.

I hereby assign payment directly to Gastroenterology Associates of Florida for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to Gastroenterology Associates of Florida for all charges in the event that my insurance is terminated or rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if Gastroenterology Associates of Florida files my insurance claim, I will remain responsible for the account and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket" expenses are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected a t the time of service. Methods of payment include check, cash and credit card.

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Florida.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records and any other information requested relating to any hospitalizations, examinations, treatments, tests, procedures or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information to my insurance company. A copy of this authorization shall be as valid as the original of this document.

## GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize Gastroenterology Associates of Florida Physicians, Practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

## RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

PATIENT NAME _____ PATIENT SIGNATURE _____

DATE _____ WITNESS SIGNATURE _____

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# OFFICE GUIDELINES

We are so glad that you have chosen Gastroenterology of Associates of Florida for your healthcare needs. We commit to treat all our patients with respect and offer not only the best care, but also the best patient (customer) service as well. Please let us know if you have a concern or need.

Some responsibility comes with being a patient:

- **It is your responsibility to have your referral with you at the time of your visit; reminders to bring your referral are a courtesy**
- **If you are unsure of referral requirements, you must contact your insurance company directly prior to your appointment**
- **If your insurance company has changed you must notify our office prior to your appointment, otherwise you may be responsible for the full payment of the visit**
- **If your address or telephone change you must notify our office; if we are unable to contact you to confirm your appointments they will be cancelled.**

**-Please note:** Due to Medicaid regulations we are unable to charge Medicaid patients a no-show fee but reserve the right to discharge all patients that consistently do not show for appointments.

******* We reserve the right to charge you for cancelling or not showing up to your appointment on the same date of your scheduled visit. The charge for same day cancellations and no show is $25.00 for each appointment. We are aware that emergencies can arise, but repeated cancellations and no shows may result in dismissal from our practice. *******

**PATIENT NAME** **ACCOUNT #**

**PATIENT SIGNATURE** **DATE**

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