



**PATIENT INFORMATION**

Acct # \_\_\_\_\_

Thank You for choosing **our practice**. We will do everything in our power to make your experience with us the best that it can be.

**Please answer all questions fully:**

Today's Date: \_\_\_\_\_

13838 US Hwy 441/27 Lady Lake, FL 32159 Phone (352) 753-1612	1950 Laurel Manor, Bldg. 240 The Villages, FL 32159 Phone (352) 753-1612	8110 CR 44 Leg A Leesburg, FL 34788 Phone (352) 323-8868	1840 Classique Ln Tavares, FL 32778 Phone (352) 323-8868	255 Citrus Tower Blvd, Suite 208A Clermont, FL 34711 Phone (352)-404-4334
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**ABOUT YOU:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Last First Middle Social Security Age Birth Date

\_\_\_\_\_  
 Local Street Address City State Zip

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
 Home Phone Work Phone Cell Phone Name of Employer

(\_\_\_\_) \_\_\_\_\_ Would you like to receive our newsletter via e-mail?  
 Out-of-State Phone E-mail  YES  NO

**CIRCLE THE ONE THAT BEST DESCRIBES YOU:** Sex: M/F Marital Status: Married Divorced Single Widowed

**Employment:** Full Part Retired None **Student:** Full Part **Ethnicity:** Hispanic or Latino Non-Hispanic or Latino

**Race:** American Indian/ Alaskan Native Asian Black/African American Native Hawaiian/ Pacific Islander White Other

**INSURANCE:**

**Primary Insurance Policy Name:** \_\_\_\_\_  
 Insurance Co Name Policy # Effective Date

**Secondary Insurance Policy Name:** \_\_\_\_\_  
 Insurance Co Name Policy # Effective Date

**Relationship to the insured:** Self Spouse Child Other \_\_\_\_\_  
 Spouse's name /Parent (if minor) Birth date Social Security #

**HOW DID YOU HEAR ABOUT US?**  Primary Care Physician  Specialist Physician  Family/ Friend  I'm a prior patient  
 Hospital  Insurance Co.  Phone Book  Billboard/ Sign  Health Fair  Website  Which Radio Station \_\_\_\_\_  
 Which Magazine \_\_\_\_\_  Which Newspaper \_\_\_\_\_  Other \_\_\_\_\_

**PHARMACY INFORMATION?**

\_\_\_\_\_  
 Primary Pharmacy Pharmacy Phone Number

**LAB USED FOR BLOODWORK INFORMATION?**

\_\_\_\_\_  
 Lab, i.e. Alliance, Labcorp, Quest, etc. Street (# not needed) City

**PHYSICIAN INFORMATION:**

\_\_\_\_\_  
 Referring Physician Phone # Primary Physician Phone #

\_\_\_\_\_  
 Other Physician Participating in your care Phone # Other Physician Participating in your care Phone #

I certify the information that I provided is correct. I authorize the release of medical information necessary to process insurance claims to my insurance companies or their agencies (including Medicare), for purpose of the filing and payment of medical claims. I authorize payment of medical benefits to the provider. I permit a copy of this release to be used in place of the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Revised-JA 10/2011





**Current Symptoms**

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**Please answer all questions fully.**

Patient name: \_\_\_\_\_

Date: \_\_\_\_\_

**Please circle any of the following problems that you may have or have had recently.**

- Abdominal pain      Chronic cough      Fecal urgency      Difficulty swallowing
- Anemia      Constipation      Feeling of food or pills stuck in throat
- Sore throat      Black stools      Diarrhea      Fecal incontinence
- Vomiting      Change in bowel habits      Chest pain      Rectal bleeding
- Nausea      Vomiting blood      Hoarseness      Indigestion
- Painful swallowing      Weight loss      Fever      Loss of appetite
- Hiatal hernia

**Please circle either Yes or No.**

Yes No Have you ever had a colonoscopy, sigmoidoscopy, or Barium Enema? If yes, when? \_\_\_\_\_.

Yes No Did you have any polyps? If yes, how many? \_\_\_\_\_.

Yes No Have you ever had an EGD (gastroscopy) or upper GI (Barium Swallow)?

**Family history:**

Yes No Anyone in your family ever had colon cancer?

Who? \_\_\_\_\_ Age diagnosed? \_\_\_\_\_ Age died? \_\_\_\_\_

Yes No Anyone in your family ever had colon polyps?

Yes No Anyone in your family ever had cancer of the liver, stomach, or pancreas?

Who? \_\_\_\_\_ Age diagnosed? \_\_\_\_\_ Age died? \_\_\_\_\_

Father died of \_\_\_\_\_ at age \_\_\_\_\_ yrs. Mother died of \_\_\_\_\_ at age \_\_\_\_\_ yrs.

**We know we already asked you this, but would you kindly write the names of your physicians one more time? Thank you**

\_\_\_\_\_  
Referring Physician and Phone Number if available

\_\_\_\_\_  
Primary Physician and Phone Number if available

\_\_\_\_\_  
Other Physician participating in your care

\_\_\_\_\_  
Other Physician participating in your care



# Billing and Insurance Policies

Acct # \_\_\_\_\_

## **CANCELLATION POLICY**

Our office has a cancellation / no-show policy in which you will be charged **\$25** for failing to cancel or reschedule your office appointment 24 hours in advance. Failing to show or cancel for a scheduled surgery, e.g. colonoscopy, EGD, hernia repair, will incur a **\$50** charge. Please make every attempt to call the office and notify us of any changes or emergencies that may interfere with your scheduled appointment with us. The time scheduled for your appointment is assigned to you and you alone.

## **FINANCIAL OBLIGATIONS**

All co-payments are due when services are rendered. Deductibles and co-insurances may also be collected at this time. Outstanding balances on your account, over 45 days, may require payment before additional services are rendered.

## **INSURANCE CLAIM FILING**

We file your insurance claims as a courtesy to you and, in most cases, provide services in good faith, prior to getting payment. If your insurance company does not respond within 60 days from the date of filing, then the balance will be transferred to you and will become the your responsibility.

## **PATIENT STATEMENTS**

You will receive a monthly statement and payment is due upon receipt. If payment is not received, or if no response to the statement is received within 45 days, further action, including outside collection agency involvement may be taken. In the event that you have a procedure performed at Lake Surgery and Endoscopy Center or Endosurg Outpatient Center, please be advised that you will receive three separate statements:

- a. **Advanced Gastroenterology and Surgery Associates\*** – physician fees
- b. **Lake Surgery or Endosurg Outpatient Center** – facility fees
- c. **Anesthesia Associates** – anesthesia fees

You may also incur charges from our pathologist\* if biopsies are obtained. **IF YOUR INSURANCE REQUIRES A SPECIFIC LABORATORY, YOU MUST NOTIFY THE SURGERY RECEPTIONIST.**

I request that payment of authorized Medicare/other insurance companies' benefits be made on my behalf to: **Advanced Gastroenterology and Surgery Associates, Lake Surgery and Endoscopy Center** and/or **Endosurg Outpatient Center** for any services rendered from the physicians and anesthesiologists associated with the above mentioned entities.

I authorize these entities to release any medical information concerning me to HCFA (Health Care Financing Administration) or any of its agents necessary to determine benefits or the benefits payable to related services.

My signature below indicates I understand and agree to the terms of service explained above. I am aware and know that I am responsible for fees associated with the cancellation policy, and all deductibles, co-insurances, and non-covered services as per my health insurance policy. I am aware that it is my responsibility to know the guidelines and limitations of my insurance policy.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



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## HIPAA Information and Consent Form    Acct # \_\_\_\_\_

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 a “friendly” version. A more complete text is available 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](http://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 may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those 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 in office policy and new technology that you might find valuable or informative, insurance items, and items pertaining to your clinical care such as: laboratory and pathology results, diagnostic results, among others.
3. 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 duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
5. We agree to provide patient with access to their medical records in accordance with state and federal laws.
6. We may change, add, delete, or modify any of these provisions to better serve the needs of both the patient and the practice.
7. 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.
8. I authorize the following people to be able receive information regarding my medical condition:

\_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_

I, \_\_\_\_\_ do 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.

**SIGN:** \_\_\_\_\_

**DATE:** \_\_\_\_\_



**Gastroenterology:**

Lily Tran, M.D.  
 Rafael Fleites, M.D.  
 Garth George, M.D.  
 Ivelisse Lopez, M.D.

**General Surgery:**

MaoHao (Charlie) Han, M.D.

**Proctology:**

Robert Gillon, D.O.

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To (Physician or Facility) : \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, request that any and all records specified below be released to Advanced Gastroenterology & Surgery Associates.

**Primary Care Physician or Specialist Office**

- Lab Reports within past 6 months – 12 months
- Office note – Last visit
- Operative/ Pathology Reports – Colonoscopy, EGD within past 12 years
- CT Scans/X-Rays/MRI/ US of abdominal area within 12 months
- Hospital records within past 12 months

**Hospital**

- Hospital records within past 12 months

**Imaging/ Radiology Facility**

- CT Scans/X-Rays/MRI/ US  
of abdominal area within 12 months

PLEASE BE ADVISED THAT THIS IS TO BE CONSIDERED A FULL AND COMPLETE AUTHORIZATION TO RELEASE ALL MEDICAL RECORDS BY ABOVE MENTIONED FACILITY.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT THE PROVIDER/FACILITY/INSURANCE COMPANY LISTED ABOVE AS THE RELEASING AGENCY IS RELEASED FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION REQUESTED.

I FUTHER UNDERSTAND THAT I AM AUTHORIZING THE RELEASE OF INFORMATION FROM THE RECORDS WHOSE CONFIDENTIALITY AND PRIVILEGED STATUS IS PROTECTED FROM FEDERAL REGULATIONS AND FLORIDA STATUTE AND THAT A RE-DISCLOSURE OF THIS INFORMATION BY THE RECEIVING AGENCY IS PROHIBITED WITHOUT WRITTEN EXPRESS PERMISSION FROM THE PATIENT.

**Signature of Patient or Empowered Representative:** \_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\* Valid for 90 days \*\*\*\*\*

Confidentiality Notice:

This message is intended only for the use of the individual or entity to which it is addressed. It may contain legal information that is privileged, confidential or medically privileged and exempt from disclosure under applicable law. If the receiver of this message is not the intended recipient, you are hereby notified that any distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return this original message to us at the above address via the United States Postal Service.