

NAME Mrs. \_\_\_\_\_  
 Ms. \_\_\_\_\_  
 Mr. \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (MI)

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

 ADDRESS \_\_\_\_\_  
 (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (zip)

TELEPHONE: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

 DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  Single  Married  Widowed  Divorced

Patient's Employer \_\_\_\_\_ Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Name of person who referred you to us \_\_\_\_\_

 Spouse's Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 (If no spouse, person to notify in case of emergency)

### INSURANCE INFORMATION

 Worker's Compensation, accident date \_\_\_\_\_  Auto Accident, date \_\_\_\_\_  Veteran's Administration

#### PRIMARY INSURANCE

Subscriber Social Security No. (if not patient) \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Insurance Card Number \_\_\_\_\_ Policy Group Number \_\_\_\_\_

Street Address \_\_\_\_\_ Policy Holder (if not patient) \_\_\_\_\_ Subscriber Date of Birth (if not patient) \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Policy Holder's Employer (if not patient) \_\_\_\_\_

 Patient Relationship to Subscriber:  
 Self  Child  
 Spouse  Other

#### SECONDARY INSURANCE

Subscriber Social Security No. (if not patient) \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Insurance Card Number \_\_\_\_\_ Policy Group Number \_\_\_\_\_

Street Address \_\_\_\_\_ Policy Holder (if not patient) \_\_\_\_\_ Subscriber Date of Birth (if not patient) \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Policy Holder's Employer (if not patient) \_\_\_\_\_

 Patient Relationship to Subscriber:  
 Self  Child  
 Spouse  Other

#### Race (For Statistical Purposes Only)

- |   |   |                                |                                      |
|---|---|--------------------------------|--------------------------------------|
| <input type="checkbox"/> American Indian/Eskimo/Aleut | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Black | <input type="checkbox"/> White       |
| <input type="checkbox"/> White Hispanic               | <input type="checkbox"/> Black Hispanic         | <input type="checkbox"/> Other | <input type="checkbox"/> No Response |

In signing this form I am authorizing you to provide me with reasonable and proper medical care by today's standards. I hereby authorize payment to be made directly to **Gastroenterology Associates** from my primary and secondary insurance (if applicable) for medical services rendered to me. This assignment will remain in effect until revoked by me in writing.

Except as otherwise agreed, I understand **Gastroenterology Associates** has the right to refuse or accept assignment of medical benefits. If my health care insurance will not allow direct payment to **Gastroenterology Associates** or **Gastroenterology Associates** chooses not to accept assignment of medical benefits, I agree to forward to **Gastroenterology Associates** all health care insurance benefits I receive for medical care at **Gastroenterology Associates** immediately upon my receipt of such payments.

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.  
I will pay by (circle one) *cash check credit card*

Person Responsible For Bill: \_\_\_\_\_  
(name) (address)

\_\_\_\_\_  
Signature of patient or patient's representative Date

**CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT  
AND HEALTH CARE PROCEDURES**

I, \_\_\_\_\_, hereby authorize **Gastroenterology Associates** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care procedures. I understand that while this consent is voluntary, if I refuse to sign this consent, **Gastroenterology Associates** can refuse to treat me.

I have been informed that **Gastroenterology Associates** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care procedures. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Gastroenterology Associates**, in writing, but if I revoke my consent, such revocation will not affect any actions that **Gastroenterology Associates** took before receiving my revocation.

I understand that **Gastroenterology Associates** has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Gastroenterology Associates** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Gastroenterology Associates** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Gastroenterology Associates** must adhere to such restrictions.

\_\_\_\_\_  
Signature of patient or patient's representative Date  
(Form **MUST** be completed before signing)

\_\_\_\_\_  
Printed name of patient or patient's representative Relationship to patient

## MEDICAL & FAMILY HISTORY FORM

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

CHART NO. \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

### Allergies

None                       Codeine                       Iodine                       Morphine                       Sulfa                       Versed  
 Aspirin                       Demerol                       Latéx                       Penicillin                       Valium                      Other \_\_\_\_\_

### Past Medical Illnesses

<input type="checkbox"/> None	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Panic Attacks/Anxiety
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> Barrett's Esophagus	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prolonged bleeding
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Triglycerides	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Cirrhosis of Liver	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> H Pylori	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Stroke or Paralysis
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney Disease/Failure	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Depression	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Transfusions
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Ulcerative Colitis
			<input type="checkbox"/> Other _____

### Previous Surgeries

<input type="checkbox"/> None	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Hernia Repair, Left Inguinal	<input type="checkbox"/> Laparotomy, Exploratory
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> EGD	<input type="checkbox"/> Hernia Repair, Right Inguinal	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Angioplasty with stent placement	<input type="checkbox"/> ERCP	<input type="checkbox"/> Hernia Repair, Umbilical	<input type="checkbox"/> Prostatectomy (total)
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Flexible Sigmoidoscopy	<input type="checkbox"/> Hernia Repair, Ventral	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Fundoplication	<input type="checkbox"/> Hysterectomy (partial)	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Cardiac Bypass	<input type="checkbox"/> Hemicolectomy, Left	<input type="checkbox"/> Hysterectomy (total)	<input type="checkbox"/> TURP
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Hemicolectomy, Right	<input type="checkbox"/> Implanted Automated Defibrillator	<input type="checkbox"/> Other _____
<input type="checkbox"/> Colectomy (total)	<input type="checkbox"/> Hemorrhoidectomy	<input type="checkbox"/> Laparotomy, Diagnostic	

### **Social History Marital Status:**

Single                       Widowed  
 Divorced                       Married  
 Separated

### **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                       2 days or less/week  
 Daily                       I quit using alcohol

### **Social History Tobacco:**

I use tobacco products                       I have never used tobacco products  
 I quit using tobacco products                       I smoke more than one pack/day  
 I smoke one pack or less/day

**Social History Occupation:**

Patient Occupation \_\_\_\_\_  Veteran

**Social History Hobbies:**

Patient Hobbies \_\_\_\_\_

**REVIEW OF SYSTEMS**

**Gastrointestinal:**

- None                       Constipation                       Flatulence                       Mucous in stool                       Soiling Stool
- Abdominal pain                       Dairy intolerance                       Heartburn                       Nausea                       Trouble swallowing
- Belching                       Dark stools                       Hemorrhoids                       Pain with bowel movement                       Vomiting
- Bloating                       Decreased appetite                       Indigestion                       Rectal bleeding                       Other \_\_\_\_\_
- Change bowel habits                       Diarrhea                       Jaundice                       Rectal Urgency

**Genitourinary:**

- None                       Blood in urine
- Frequent urinary infections                       Sexual difficulty
- Change in urinary frequency                       Other \_\_\_\_\_

**Skin:**

- None                       Rashes
- Dryness                       Suspicious Lesions
- Hives                       Other \_\_\_\_\_
- Itching

**Cardiovascular:**

- None                       Ankle Swelling                       Chest Pain                       Shortness of Breath                       Other \_\_\_\_\_

**Neurological:**

- None                       Other \_\_\_\_\_
- Dizziness
- Frequent Headaches
- Numbness in Extremities

**Constitutional:**

- None                       Weight gain
- Fatigue                       Weight loss
- Fever                       Night sweats
- Loss of Appetite                       Other \_\_\_\_\_

**Psychiatric:**

- None                       Panic Attacks/ Anxiety
- Depression                       Other \_\_\_\_\_
- Difficulty Sleeping

**Eyes:**

- None                       Night Sensitivity
- Change in Vision                       Pain
- Inflammation                       Other \_\_\_\_\_

**Hematologic:**

- None                       Swollen Glands
- Easy bruising                       Other \_\_\_\_\_
- Prolonged Bleeding

**Ears, Nose and Throat:**

- None                       Sores in Mouth
- Hearing loss                       Other \_\_\_\_\_
- Hoarseness

**Respiratory:**

- None                       Wheezing
- Cough up blood                       Other \_\_\_\_\_
- Coughing

**Immunologic:**

- None                       Flu
- Ear Infections                       Other \_\_\_\_\_



**Gastroenterology Associates of St. Augustine, PA/  
St. Augustine Endoscopy Center**

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Revised 11/3/06 s://forms/general use forms/authorization to release healthcare information.doc

**Do you wish to authorize your caregivers' to discuss your condition and treatment and financial record with friends or family members?**

Please give us the names of those individuals.

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

## SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES.

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of the patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- \* A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy.
- \* A patient has the right to a prompt and reasonable response to questions and request.
- \* A patient has the right to know who is providing medical services and who is responsible for his or her care.
- \* A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- \* A patient has the right to know what rules and regulations apply to his or her conduct.
- \* A patient has the right to be given by his health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- \* A patient has the right to refuse treatment, except as otherwise provided by law.
- \* A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- \* A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- \* A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- \* A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- \* A patient has a right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- \* A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide medical treatment.
- \* A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

## RESUMEN Y RESPONSABILIDADES DE LOS DERECHOS CIVILES DE LOS PACIENTES DE LA FLORIDA

La ley de la Florida requiere que su proveedor de salud, al igual que las facilidades reconozcan sus derechos mientras usted está recibiendo atención médica, siempre y cuando usted respete las indicaciones de su proveedor de salud o de las facilidades de salud. Usted puede solicitar copia del texto completo de esta ley a su proveedor de salud o a sus facilidades de salud. Un resumen de sus derechos y responsabilidades a continuación:

- \* El paciente tiene derecho a ser tratado con cortesía y respeto, con apreciación de su dignidad individual y con la protección necesaria de su privacidad.
- \* El paciente tiene derecho a una respuesta rápida y razonable a sus preguntas y pedidos.
- \* El paciente tiene el derecho a saber quién provee los servicios médicos y quién es responsable por su cuidado.
- \* El paciente tiene el derecho a saber los servicios de apoyo al que tiene derecho y si existen los servicios de un intérprete en caso de que no hable inglés.
- \* El paciente tiene el derecho a saber cuales reglas y regulaciones se aplican a su conducta.
- \* El paciente tiene el derecho a que el proveedor de salud le provea información respecto al diagnóstico, tratamiento, riesgos, alternativas y pronósticos.
- \* El paciente tiene el derecho de rechazar tratamiento, excepto aquellos que se proveen por ley.
- \* El paciente tiene el derecho, si lo pide, a toda la información y la orientación necesaria sobre los recursos financieros disponibles para su cuidado.
- \* El paciente que es elegible a Medicare, tiene derecho a saber de ante mano, si el tratamiento de salud o las facilidades de cuidado aceptan la tarifa designada por Medicare.
- \* El paciente tiene el derecho a recibir un estimado razonable del costo por atención médica, si lo pide antes de recibir tratamiento.
- \* El paciente tiene el derecho a recibir una copia clara del estado de cuenta y explicación de los cargos, si así lo pide.
- \* El paciente tiene el derecho a recibir tratamiento médico o acomodo sin importar su raza nacionalidad de origen, religión, impedimento físico, o manera de pago.
- \* El paciente tiene el derecho a recibir tratamiento de emergencia por cualquier condición médica que pueda empeorar si se le niega tratamiento.
- \* El paciente tiene el derecho a saber si el tratamiento médico es para propósitos de investigación experimental y dar su consentimiento o rechazar su participación en tal investigación experimental.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida Law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

\*A patient is responsible for providing the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

\*A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

\*A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

\*A patient is responsible for following the treatment plan recommended by the health care provider.

\*A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

\*A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

\*A patient is responsible for assuring that the financial obligations for his or her health care are fulfilled as promptly as possible.

\*A patient is responsible for following health care and facility rules and regulations affecting patient care and conduct.

#### FILING COMPLAINTS

If you have a complaint against a hospital or ambulatory surgical center, call the Consumer Assistance Unit at 1-888-419-3456 (press 1) or write to the address listed below:

AGENCY FOR HEALTH CARE ADMINISTRATION  
CONSUMER ASSISTANCE UNIT  
2727 MAHAN DRIVE/BLDG. 1  
TALLAHASSEE, FL 32308

If you have a complaint against a health care professional and want to receive a complaint form, call the Consumer Services Unit at 1-888-419-3456 (press 2) or write to the address listed below:

AGENCY FOR HEALTH CARE ADMINISTRATION  
CONSUMER SERVICES UNIT  
P.O. BOX 14000  
TALLAHASSEE, FL 32317-4000

El paciente tiene derecho a expresar cualquier queja con relación a violaciones de sus derechos por la ley de la Florida, a través de procedimiento de quejas del proveedor de servicios de salud o las facilidades de cuidado de la salud que atienda su caso y de la agencia del estado que otorga las licencias.

\*El paciente es responsable por proveer información completa sobre su estado de salud a su mejor entendimiento, información completa acerca de quejas recientes, pasadas enfermedades, hospitalizaciones, medicamentos y otras causas relacionadas con su salud.

\*El paciente es responsable por reportar a su proveedor de salud cambios inesperados sobre su condición de salud.

\*El paciente es responsable por reportar a su proveedor de salud si ha considerado y entiende el curso de acción que va a tomar y lo que se espera de él.

\*El paciente es responsable de seguir el tratamiento de salud que le ha recomendado su proveedor de salud.

\*El paciente es responsable por mantener sus citas, y si por alguna razón no puede mantenerlas, debe notificárselo a su proveedor de salud o a la facilidad de salud.

\*El paciente es responsable por sus acciones, en el rechazo de tratamiento y si no sigue las instrucciones del proveedor de salud.

\*El paciente es responsable de asegurarse que las obligaciones financieras por su cuidado de salud sean cumplidas lo más rápido posible.

\*El paciente es responsable de seguir las reglas y regulaciones de la facilidad que afectan el cuidado y condición del paciente.

#### SOMETIMIENTO DE QUEJAS

Si usted tiene alguna queja contra el hospital o el centro quirúrgico ambulatorio, llame a la Unidad de Asistencia al Consumidor al 1-888-419-3456 (Presione el 1) o escriba a la siguiente dirección:

AGENCY FOR HEALTH CARE ADMINISTRATION  
CONSUMER ASSISTANCE UNIT  
2727 MAHAN DRIVE/BLDG. 1  
TALLAHASSEE, FL 32308

Si usted tiene alguna queja contra un profesional del cuidado de la salud y quiere recibir un formulario de quejas, llame a la Unidad de Asistencia al Consumidor al 1-888-419-3456 (Presione el 2) o escriba a la siguiente dirección:

AGENCY FOR HEALTH CARE ADMINISTRATION  
CONSUMER SERVICES UNIT  
P.O. BOX 14000  
TALLAHASSEE, FL 32317-4000

St. Augustine Endoscopy Center

**Disclosure of Ownership**

**St. Augustine Endoscopy Center is owned by the following physicians:**

Santiago A. Rosado, MD, FACP, FACG  
Steven Y. Villanueva, MD  
Timothy J. Cavacini, DO  
Stuart A. Soroka, MD  
Daniel J. Gassert, MD  
William J. Barlow, MD

**Patient Rights and Responsibilities**

You are being provided with a copy of the State of Florida Patient Rights and Responsibilities in English and Spanish.

**How to File a Grievance with the State of Florida**

Within the Patient Bill of Rights and Responsibilities, you will find information regarding how to file a grievance.

**Advance Directives**

St. Augustine Endoscopy Center does not maintain or honor advance directives in this practice. In a life threatening situation, CPR is administered and 911 is contacted to transport the patient to Flagler Hospital. Upon request, we will provide you with an advance directive form which you may complete and file with your Primary Care Physician

The above information has been discussed and a written copy has been provided.

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Printed Patient Name

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Signature of Patient or Legal Guardian

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Date Signed

Gastroenterology Associates of St. Augustine  
St. Augustine Endoscopy Center  
216/212 Southpark Circle, East  
St. Augustine, FL 32086  
(904) 824-6108

**Receipt of Notice of Privacy Practices**

**Written Acknowledgement Form**

I, \_\_\_\_\_, have received a copy of  
Print Patient's Name

**Gastroenterology Associates of St. Augustine, P.A./St. Augustine  
Endoscopy Center's Notice of Privacy Practices.**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date