GASTRO HEALTH

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PATIENT INTERVIEW FORM

PATIENT INFORMATION

First Name:_____ Last Name: _____

Date of Birth: _____

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ Unknown ☐ Patient declines to provide information

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Gender

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ French ☐ Portuguese ☐ Spanish ☐ Creole ☐ Other: _____

PHARMACY

Name:_____ Phone Number _____

CURRENT MEDICATIONS

☐ None

Name	Dose	How Taken?

PAST OR PRESENT MEDICAL CONDITIONS

- [ ] None
- [ ] AICD/Pacemaker
- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Bleeding Problems
- [ ] Cancer - Colon
- [ ] Cancer - Other
- [ ] Celiac Disease
- [ ] Chest Pain
- [ ] Cirrhosis of Liver
- [ ] Colon Polyps
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diabetes
- [ ] Diverticulitis
- [ ] Fatty Liver
- [ ] Fibromyalgia
- [ ] Gallbladder Disease
- [ ] Gastroesophageal Reflux Disease (GERD)
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] HIV/AIDS
- [ ] Irritable Bowel Syndrome
- [ ] Kidney Disease/Failure
- [ ] Lactose Intolerance
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Multiple Sclerosis
- [ ] Neurologic Disorders
- [ ] Pancreatitis
- [ ] Prostate Enlargement
- [ ] Sleep Apnea
- [ ] Stomach / Duodenal Ulcer
- [ ] Stroke
- [ ] TB (Tuberculosis)
- [ ] Thyroid Disease
- [ ] Ulcerative Colitis
- [ ] Other _____

ALLERGIES

- [ ] Patient has no known allergies
- [ ] Aspirin
- [ ] Codeine Sulfate
- [ ] Eggs
- [ ] Iodine/Iodine-Containing Products
- [ ] Morphine
- [ ] Penicillin's
- [ ] Sulfa (Sulfonamides)
- [ ] Latex
- [ ] Soy
- [ ] Other: _____

DIAGNOSTIC STUDIES / TESTS

- [ ] None
- [ ] Colonoscopy When: _____
- [ ] EGD When: _____
- [ ] ERCP When: _____
- [ ] Liver Biopsy When: _____
- [ ] Enteroscopy When: _____
- [ ] EUS When: _____
- [ ] Capsule Endoscopy When: _____
- [ ] Stress Test When: _____
- [ ] Echocardiogram When: _____

PREVIOUS PROCEDURES

- [ ] None
- [ ] Abdominoplasty Tummy Tuck When: _____
- [ ] Appendectomy When: _____
- [ ] Bariatric Surgery When: _____
- [ ] Breast When: _____
- [ ] Bladder Surgery When: _____
- [ ] Coronary Bypass Surgery When: _____
- [ ] Breast When: _____
- [ ] C-Section When: _____
- [ ] Colon Resection When: _____
- [ ] Colostomy When: _____
- [ ] Hysterectomy Surgery When: _____
- [ ] Colon Resection When: _____
- [ ] Hiatal Hernia Repair When: _____
- [ ] Gallbladder Surgery When: _____
- [ ] Hemorrhoid Surgery When: _____
- [ ] Stomach When: _____
- [ ] Inguinal Hernia Repair When: _____
- [ ] Ovary Surgery When: _____
- [ ] Prostate When: _____
- [ ] Thyroid When: _____
- [ ] Umbilical Hernia Repair When: _____
- [ ] Other _____

FAMILY MEDICAL HISTORY

☐ No knowledge of family history

No family history of ☐ Colon Cancer ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Colon Polyps ☐ Liver Disease

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Healthy	☐	☐	☐	☐	☐	☐
Deceased / at Age	_____	_____	_____	_____	_____	_____
Diagnoses						
Celiac Disease	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐
Ulcer Disease	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Occupation:_____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol

None ☐

	Type	Quantity
☐ Rarely		
☐ Less than 2 days/week		
☐ More than 2 days/		
☐ week I quit using		

Tobacco

Smoking Status ☐ Current daily smoker ☐ Current weekly smoker ☐ Former smoker ☐ Never smoker

☐ Smoker, current status unknown ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				
☐ Pipe				

Drug Use

☐ None

Type

☐ I have never used recreational drugs ☐ I have used recreational drugs in the past

☐ I am currently using recreational drugs ☐ I have been treated for substance abuse

REVIEW OF SYSTEMS

CONSTITUTIONAL
☐ None

Yes	No	
☐	☐	fatigue
☐	☐	fever
☐	☐	weight loss

RESPIRATORY
☐ None

Yes	No	
☐	☐	cough
☐	☐	shortness of breath

CARDIOVASCULAR
☐ None

Yes	No	
☐	☐	chest pain
☐	☐	palpitations

GASTROINTESTINAL
☐ None

Yes	No	
☐	☐	gas
☐	☐	heartburn
☐	☐	nausea
☐	☐	vomiting
☐	☐	trouble swallowing
☐	☐	abdominal pain
☐	☐	change in bowel habits
☐	☐	constipation
☐	☐	diarrhea
☐	☐	soiling/incontinence
☐	☐	rectal bleeding
☐	☐	rectal pain
☐	☐	hemorrhoids
☐	☐	jaundice

HEMATOLOGIC/LYMPHATIC
☐ None

Yes	No	
☐	☐	easy bruising/bleeding

GENITOURINARY
☐ None

Yes	No	
☐	☐	dark urine

MUSCULOSKELETAL
☐ None

Yes	No	
☐	☐	joint pain

INTEGUMENTARY
☐ None

Yes	No	
☐	☐	rash

NEUROLOGICAL
☐ None

Yes	No	
☐	☐	headaches

PSYCHIATRIC
☐ None

Yes	No	
☐	☐	anxiety/depression
☐	☐	memory loss/confusion

IMMUNIZATIONS
☐ None

☐ Flu When:_____
☐ Hepatitis A When:_____
☐ Hepatitis B When:_____
☐ Pneumonia When:_____
☐ HPV When:_____
☐ Shingles When:_____
☐ Tetanus When:_____
☐ Other: When:_____

Financial Policy

Gastro Health – Florida

Below are the Financial Policies of Gastro Health Holdco, LLC, and its subsidiaries (hereinafter referred to collectively as Gastro Health); All references of policies throughout this document shall apply equally to all subsidiaries of Gastro Health Holdco, LLC, its physicians and services, which will be referred to collectively as "Gastro Health" herein.

INSURANCE INFORMATION

Your health insurance is a contract between you and your insurer. Any charges not paid by your insurer for any reason are your responsibility. **It is your responsibility to understand your insurance benefits, including plan limitations, the difference between screening or preventative care benefits versus diagnostic procedure benefits and the need for referrals or pre-authorizations.** We will make every effort to verify your benefits, identify your financial liabilities and pre-authorizations prior to your appointment on your behalf; however, this is not a guarantee of payment. We will bill your insurance for all services we provide; however, **we require you to pay any portion of your financial liability for care**, including/not limited to co-pays, deductibles or co-insurance, **prior to the service**. Certain services performed by our office, for your benefit, may not be covered by your insurance plan(s). Gastro Health suggests you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility. Please note if you obtain a policy from the Affordable Care Act marketplace, and are issued a subsidy, but fail to pay your premium during the grace period, your care will be entirely your financial responsibility. CERTAIN INSURANCES OR EMPLOYERS MAY HAVE A NARROW NETWORK THAT EXCLUDES YOUR PHYSICIAN. IF OUR SERVICES ARE DEEMED OUT OF NETWORK AND YOUR BENEFIT PLAN HAS NO OUT OF NETWORK BENEFITS, IT IS THE PATIENT'S RESPONSIBITY TO PAY FOR THE SERVICES IN FULL. PLEASE CONSULT WITH YOUR PLAN IN ADVANCE OF YOUR VISIT.

ADMINISTRATIVE FEES

I understand that there is a $35 charge for returned checks for any reason. Failure to remedy the returned check may result in legal action. I understand that missed or cancelled office visit appointments with less than 24 hours' notice will result in a fee of $25. I understand that missed or cancelled procedure appointments with less than 72 hours' notice will result in a fee of $75. Our fee for completing forms is $25. There is a charge for copying medical records in accordance with state laws.

Gastro Health Credit on File Policy

Gastro Health is committed to reducing waste and inefficiency and making our billing process as simple as possible. We require that you provide a credit card on file with our office. We run payments through a secure, HIPAA and PCI-compliant merchant services application. The security of your private information is our priority. For your protection, only the last 4 digits of your card will show in the system. We will process your payment automatically, sending you a receipt via email (if we have one on file). Your ability to dispute your insurance company's charges will not be compromised. Patients without insurance or patients that do not authorize a credit card to be kept on file for account balances will need to make payment in full on the day of the visit.

Credit Cards on File will be used to pay account balances after insurance adjudication.

1) Once your insurance has processed your claim, they will send an Explanation of Benefits (EOB) to both you and our office showing what your total patient financial responsibility is. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier and our office immediately.

2) When we receive the EOB, we will enter this information in our system. Your credit card is processed only after the claim has been processed by your insurer. **If your total amount owed is $300 or less, we will process the payment on your credit card on file and send a receipt to your email (if we have one on file). If the balance is greater than that, the remainder of the balance may be manually charged for the same date of service at a later date or you will receive a second statement for the remaining balance.**

Consent to Receive Text Messages from Gastro Health

PATIENT/LEGAL GUARDIAN CONSENT: I give Gastro Health and its staff and patient notification service permission to contact me via my cellular device for automated phone calls and SMS text messages. I understand that emergency notifications are excluded from this permission and will be sent as normal. I understand that message/data rates may apply to messages sent through Gastro Health to my mobile phone. I understand that I am under no obligation to authorize Gastro Health to send you text messages as part of this program. By signing, I certify that I am the owner of this cellular device and its user contract.

Additionally, by signing below, I understand and accept the financial policies of Gastro Health, including the credit card on file policy. I authorize the use of my credit card for outstanding balances only after my insurance has processed my claim but not

more than six (6) months after my visit. I give Gastro Health permission to apply payments to any balances amongst its locations. I understand that I am ultimately financially responsible for the services I receive from Gastro Health. Should I neglect to meet my financial responsibility, I understand that I may be charged additional fees incurred in the collection process, including from third party collection agencies.

Name: _____

Signature: _____

Date: _____/_____/_____

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PATIENT INFORMED CONSENT FOR TREATMENT AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

GENERAL TREATMENT CONSENT: The undersigned has voluntarily presented for medical care and consents to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary or appropriate for the purpose of diagnosis. Procedures or exams may include, but are not limited to anoscopy, breath tests, capsule endoscopy, fibroscan, hemorrhoid banding, ultrasound, and rectal exam. The undersigned understands that the nature of, intended purpose, potential risks/complications, and alternatives for each procedure or treatment will be explained to him/her beforehand. The undersigned understands and acknowledges that no warranty or guaranty has been or will be made as to the result or cure of treatment.

NOTICE OF PRIVACY PRACTICES ACKOWLEDGEMENT: The undersigned understands he/she has a right to review the Provider's Notice of Privacy Practices prior to signing this document and acknowledges that the Provider's Notice of Privacy Practices has been made available to him/her. The Notice of Privacy Practices for the Provider is also provided in the waiting room.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND FINANCIAL CONSENT

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION? May we disclose your protected health information to your: spouse, adult children, siblings, attorney, Life Insurance Company or other entity? If yes, please write their name, contact information and relationship to you.

Person/Organization Name_____

Relationship_____

Address_____

City_____ State _____ Zip Code _____

Phone (_____) _____ Fax (_____) _____

Person/Organization Name_____

Relationship_____

Address_____

City_____ State _____ Zip Code _____

Phone (_____) _____ Fax (_____) _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All Health Information**
- ☐ History/Physical Exam
- ☐ Past/Present Medications
- ☐ Lab Results
- ☐ Physician's Orders
- ☐ Patient Allergies
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Diagnostic Test Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Radiology Reports
- ☐ Imaging Films
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (Excluding psychotherapy notes)

_____ Drug, Alcohol, or Substance Abuse Records

_____ Genetic Information (Including Genetic Test Results)

_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

Month_____Day_____Year_____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. If I revoke this Authorization, I must send a written request to: **GASTRO HEALTH, LLC 9500 S. Dadeland Blvd. Suite 200, Miami, FL 33156 ATTN: Privacy Officer**. I understand that the revocation will not apply to information that has already been released in reliance on this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

MOBILE PHONE COMMUNICATION CONSENT: By signing this document, you consent to your mobile phone number to be used to communicate with you by text or voice through an automated or pre-recorded message to provide you with information related to your healthcare, account or bills for healthcare services, and information related to additional healthcare services that may be of interest to you. You are not required to provide us with your mobile phone number for these purposes.

If you have not provided Gastro Health with your mobile phone number, you may provide it here: (_____) _____-_____.

INSURANCE INFORMATION: Your health insurance is a contract between you and your insurer. Any charges not paid by your insurer for any reason are your responsibility. It is your responsibility to understand your insurance benefits, including plan limitations, the difference between screening or preventative care benefits versus diagnostic procedure benefits and the need for referrals or pre-authorizations. We will make every effort to verify your benefits, identify your financial liabilities and pre-authorizations prior to your appointment on your behalf; however, this is not a guarantee of payment. We will bill your insurance for all services we provide; however, we require you to pay any portion of your financial liability for care, including/not limited to co-pays, deductibles or co-insurance, prior to the service. Certain services performed by our office, for your benefit, may not be covered by your insurance plan(s). Gastro Health, LLC suggests you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility. Please note if you obtain a policy from the Affordable Care Act marketplace, and are issued a subsidy, but fail to pay your premium during the grace period, your care will be entirely your financial responsibility. CERTAIN INSURANCES OR EMPLOYERS MAY HAVE A NARROW NETWORK THAT EXCLUDES YOUR PHYSICIAN. IF OUR SERVICES ARE DEEMED OUT OF NETWORK AND YOUR BENEFIT PLAN HAS NO OUT OF NETWORK BENEFITS, IT IS THE PATIENT'S RESPONSIBITY TO PAY FOR THE SERVICES IN FULL. PLEASE CONSULT WITH YOUR PLAN IN ADVANCE OF YOUR VISIT.

ADMINISTRATIVE FEES: I understand that there is a charge for returned checks for any reason (check with your office's staff for specific fees charged). Failure to remedy the returned check may result in legal action. I understand that missed appointments or appointments cancelled with less than 24 hours' notice, for office visits, and 48 hours for procedures, may result in a fee of in accordance with the applicable office or facility policies. Additionally, there may be a fee charged for completing forms (check with your office's staff for specific fees charged) and copying medical records in accordance with State laws.

PAYMENT: Gastro Health, LLC is committed to reducing waste and inefficiency and making our billing process as simple as possible. We require that you provide a credit card on file with our office. We run payments through a secure, HIPAA and PCI-compliant merchant services application. The security of your private information is our priority. For your protection, only the last 4 digits of your card will show in the system. We will process your payment automatically, sending you a receipt via email (if we have one on file). Your ability to dispute your insurance company's charges will not be compromised. Patient's without insurance or patient's that do not authorize a credit card to be kept on file for account balances will need to make payment in full on the day of the visit.

OPEN BALANCES: You may have outstanding balances for more than one location within the practice. We reserve the right to collect on balances for any subsidiary of Gastro Health, LLC. Note: Credit card payments are only accepted in our offices or through our website and will not be processed if mailed to our central billing office. Patients who fail to adhere to our financial policies may be sent to collections, occur additional costs up to 25% of the balance and be terminated from our practice. Identified balances on account may be refunded only during the final week of the month.

PATIENT'S RELEASE STATEMENT: *By signing below, I understand and accept the financial policies of Gastro Health, LLC, including the credit card on file policy. I authorize the use of my credit card for outstanding balances only after my insurance has processed my claim but not more than six (6) months after my visit. I give Gastro Health, LLC permission to apply payments to any balances amongst its locations. I understand that I am ultimately financially responsible for the services I receive from Gastro Health, LLC. Should I neglect to meet my financial responsibility, I understand that I may be charged additional fees incurred in the collection process, including from third party collection agencies.*

SIGNATURE AUTHORIZATION: I have read this form and agree to the use and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____

Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other_____

SIGNATURE X _____ _____

Signature of Minor Individual DATE