Bardmoor Gastroenterology
GASTROENTEROLOGY AND LIVER DISEASES
8787 BRYAN DAIRY ROAD, SUITE 310, SEMINOLE, FL 33777
PHONE (727) 393-1155 FAX (727) 320-9634

HEALTH QUESTIONNAIRE

DATE: ______________________________

NAME: ____

PRIMARY CARE DOCTOR____

REASON FOR VISIT____

PHARMACY NAME______________________PHONE#________________FAX#________________

ALLERGIES____

ILLNESS OR OPERATION____

Pacemaker_________________________Defibrillator__________________________

FAMILY HISTORY – BLOOD RELATIVES

(LIST ANY ILLNESSES)____

VACCINES (YEAR OF LAST VACCINATION)

HEPATITIS____________________________INFLUENZA (FLU) _____________________________

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

___ Bleeding or bruising tendency
___ Anemia
___ Past Transfusion
___ Swollen glands
___ Poor appetite
___ Difficulty swallowing
___ Heartburn
___ Nausea
___ Vomiting
___ Bloating/belching
___ Constipation
___ Diarrhea
___ Blood in stool
___ Abdominal pain
___ Recent change in bowel habits
___ Rectal bleeding
___ Recent weight change
___ Fever/night sweats
___ Fatigue/ weakness
___ Loss of appetite

___ Rash
___ Itching
___ Heat/ cold intolerance
___ Excessive thirst
___ Hair Loss
___ Excessive sweating
___ Headache
___ Lightheaded/dizziness
___ Numbness/ tingling
___ Seizure
___ Blurred vision
___ Contact with irritant
___ Eye disease
___ Diminished vision
___ Drainage from eyes
___ Hearing loss
___ Ringing in ears
___ Nose bleeds
___ Sore throat
___ Voice change

___ Chronic cough
___ Chest pain
___ Palpitations
___ Shortness of breath
___ Swelling of ankles
___ Joint pain
___ Joint swelling
___ Joint stiffness
___ Leg cramps
___ Memory loss/confusion
___ Depression
___ Tension/ stress
___ Sleep disturbances
___ Difficulty urinating
___ Blood in urine
___ Heavy periods
___ Dysmenorrhea
___ Family History GI Cancer
___ Family History Colon Polyps

You do not need to fill this out if you have your own list, please provide us with a copy, or bring your list so we can copy in office.

Medication Log

Name: ______________________________

Please include OTC meds.

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Time	am
					pm

INSURANCE

It is the patient's responsibility to notify the office of any change in their insurance. Patients who carry any form of medical insurance should know that all services furnished are charged directly to the patient and he or she is responsible for payment. We will prepare any necessary forms to assist in making collections from your primary insurance company and credit such collections to your account. You will also be expected to pay any benefit proceeds from your insurance to this office. However, we cannot render services on the assumption that your charges will be paid solely by your insurance. Most misunderstandings about insurance can be avoided if you understand what your policy provides. Many insurances policies pay according to a schedule of benefits that is based on various criteria. This office charges fees, which are reasonable in this community. Not all insurance will pay 100% of our charges. The patient (and/or spouse, guarantor) is responsible to pay all sums unpaid by insurance. If it becomes necessary to collect sums due through an attorney, then the patient (and/or spouse, guarantor) agrees to pay all reasonable cost of collection, including attorney's fees, whether suit is filed or not. The patient authorizes the release of any information acquired in the course of treatment as necessary to file any insurance claims.

OFFICE POLICY ON TEST RESULTS

NO test results will be given to the patient over the phone. The patient needs to set an appointment to come in for all test results.

RELEASE OF MEDICAL INFORMATION TO FAMILY AND FRIENDS (OPTIONAL)

This office will NOT release any medical information to family and friends of the patient. Any patient wishing to grant access to all medical information to any family or friends must fill out and sign the release below.

I, ___________________________, give the office of Dr. AJ Bidani permission to release all my

PATIENT NAME

medical information to _____________________________, _________________________,

NAME OF PERSON RELATIONSHIP TO PATIENT

______________________.

DATE OF BIRTH

Bardmoor Gastroenterology
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DIPLOMAT: AMERICAN BOARD OF INTERNAL MEDICINE AND GASTROENTEROLOGY
8787 BRYAN DAIRY ROAD, SUITE 340, LARGO, FL 33777
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OFFICE POLICIES

APPOINTMENTS:
It is the policy of this office that if a patient calls in with an emergent problem and the doctor is in the office, the patient will be worked in. There are no office hours on Saturday.

CANCELLATIONS:
It is the policy of this office that any office visit cancelled less than 24 hours of schedule appointment will be charged a $35.00 fee for office visits or a $50.00 fee for surgical procedures.

REFERRALS:
It is the patient's responsibility to make sure a referral is obtained by the primary care doctor, giving the primary care provider ample time to obtain the referral. This office will assist, when necessary, in helping to obtain the authorization for the visit.

COPAYS:
Copays are to be collected at the time of the office visit, unless other arrangements are made in advance.

REFILLS:
The patient is asked to please give our office 48 hours for prescription refills. The patient needs to know the name of the medicine, the strength (dosage)of the medication being requested, and the number of the pharmacy. All refills are done during regular office hours only. No refills will be called in over the weekend.

CHANGES IN ADDRESS, PHONE NUMBERS, OR INSURANCE:
It is the patient's responsibility to notify the office of any changes in address, phone number, or insurance.

PAYMENT:
Payment is due upon receipt of the services provided by the doctor. Cash, credit cards, and checks are accepted.

COPYING OF MEDICAL RECORDS:
1. Copying of medical records requires a medical record release signed by the patient before records are copied
2. A charge of $1.00 per page will be charged to the patient and will be collected at the time the records are to be picked up
3. No medical records will be faxed with the exception of faxing to another physician's office

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I, ____, hereby authorize Bardmoor Gastroenterology 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 healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Bardmoor Gastroenterology can refuse to treat me.

I have received a copy of the Notice of Privacy PRACTICES ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and healthcare operations.

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

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

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

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There are over 1000 insurance plans in America. Most insurance carriers differ on a per patient basis. Therefore, it is impossible for our office to know the covered benefits of your insurance plan.

Please be sure to contact your current insurance carrier to verify our participation with your carrier and to verify coverage information if you are uncertain what your plan covers. It is the responsibility of the patient to know and understand eligibility, policies, procedures, services, and benefits of their insurance. This includes but is not limited to:

- Referral requirements must be given to our office staff prior to any services being rendered
- Co-insurances
- Co-payments
- Deductibles
- Covered hospital services (admissions, diagnostic testing, labs, x-rays, etc.)
- Prior authorization procedures
- Correct insurance subscriber information and current claims address

When contacting your insurance carrier regarding coverage questions or concerns, it would be wise to document the name of the person you are speaking to and the date and time you called. Some carriers will offer a reference number for the call. *Remember to keep this information for future reference.*

It is important for you to understand that the physician must document and code according to what services were provided to you, regardless of your coverage. Please be mindful that the insurance carriers determine what services are covered under your policy, not the physicians.

Please keep the office informed of any changes in your address, telephone number, or insurance information. We will be happy to submit an insurance claims to your primary and secondary insurance carriers, but we must have the most recent and accurate information to do so. Your insurance cards mut be presented at your initial visit and when you change carriers.

Thank you in advance for your cooperation.

____ ____________________

Signature of Patient or Patient’s Representative Date

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PATIENT INFORMATION FORM

____ ________________________

LAST NAME FIRST NAME MI DATE OF BIRTH

____ ________________________

STREET ADDRESS CITY, STATE, & ZIP CODE

____ ________________________

SOCIAL SECURITY # DRIVER'S LICENSE #

________________ ________________ ________________

HOME PHONE # WORK # CELL #

____

OCCUPATION/EMPLOYER

____ ________________________

SPOUSE'S NAME SPOUSE'S DATE OF BIRTH

____

IF UNDER 18, PATIENT/GUARDIAN

____ ________________________

EMERGENCY CONTACT (OTHER THAN SPOUSE) PHONE #

____ ______________________

EMERGENCY CONTACT ADDRESS RELATION

________________ ________________ ________________

PRIMARY INSURANCE CONTRACT# GROUP#

________________ ________________ ________________

SECONDARY INSURANCE CONTRACT# GROUP#

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Bardmoor Gastroenterology for services rendered by their physicians in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Bardmoor Gastroenterology to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE

I certify the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original

____ ______________________

PATIENT NAME (PLEASE PRINT) DATE

____ ______________________

PATIENT SIGNATURE PARENT/GUARDIAN