

Bardmoor Gastroenterology & Wellness

8787 Bryan Dairy Road Suite 340 Largo, FL 33777

Phone (727) 393-1155

Fax (727) 320-9634

Patient Information & Health Questionnaire

Last Name: _____ First Name: _____

D.O.B: ____ / ____ / ____ Height: _____ Weight: _____ Gender: _____

Race: _____ Ethnicity: _____

Current Address: _____

Driver's License Number: _____ State: _____

Home phone: _____ Cell phone: _____ Leave messages? ___ Yes ___ No

Email address: _____

Occupation/Employer: _____ Work phone: _____

Are you currently single / married / divorced / widowed? _____

Do you have children? ___ Girls ___ Boys

Emergency contact name: _____ Phone: _____

Emergency contact address: _____

Secondary Emergency contact: _____ Phone: _____

Advanced Directive: Are you the sole decision-maker for your medical decisions? _____

Do you have a medical surrogate or healthcare advocate (an individual that makes medical decisions for you)? _____

Do you have a do not resuscitate order? _____ Do you have a living medical will? _____

Today's Date: _____

Primary Doctor: _____ Reason for visit: _____

Pharmacy Name: _____ Pharmacy City: _____

Drug Allergies: _____

Prior Medical Diagnoses: _____

Surgical History: _____

Past Hospitalizations: _____

Do you have a pacemaker? _____ Do you have a defibrillator? _____

Family History: (Diabetes, Hypertension, Heart Disease, Mental illness, Stroke, Cancer)

Father: _____ Mother: _____

Paternal grandfather: _____ Paternal grandmother: _____

Maternal grandfather: _____ Maternal grandmother: _____

Siblings: _____ Children: _____

Does anyone related to you have a history of GI cancer and/or polyps? _____

Patient Appointment Agreement

We value you as our patient and need your cooperation with keeping appointment times. We strive to provide our patients with the best possible care by reducing unnecessary wait times. Missing or cancelling appointments in less than 24 hours means we are unable to see a patient that needs care. Please help everyone's wait times by ensuring that you arrive on time or coordinate to cancel appointments in advance appropriately. We appreciate your business, and your assistance allows us to provide timelier care for all patients while reducing costs to everyone.

Appointment Cancellations: If you need to cancel your appointment, you must give us at least **48 hours' notice prior to your appointment time**. Cancellations made with **less than 48 hours' notice** will be charged a **\$25 USD** late notice fee.

Procedure Cancellations: If you need to cancel your procedure, you must give us at least **48 hours' notice prior to your appointment time**. Cancellations made with **less than 48 hours' notice** will be charged a **\$50 USD** late notice fee. Please bear in mind the surgery center may also charge a fee as they have to arrange staffing in advance.

Compliance: Patients are only allowed **TWO missed appointments** in a **12-month period**. After the second missed appointment, you will not be scheduled for further appointments until you reconcile the full balance on the account. However, you are welcome to "walk-in" and be seen based on that day's availability, which may greatly range in wait times.

Late Arrivals: Please call if you will be arriving late. If you are more than **30 minutes late** to your time slot, and do not call, we will give your appointment to another patient, and you will be seen as availability occurs. If you are late to a procedure, please call, you may have to forfeit your time slot and will still be responsible for the surgery center fees, depending on their policy.

Missed Appointments: If you miss an appointment and **do not call to notify us**, this will be considered a **no-show appointment**, and you will be charged a **\$50 USD fee for office visits**.

Missed Procedures: A missed procedure is when you **do not show up** and **do not call to notify us**, a **\$100 USD minimum fee** will be charged for all missed procedures. Please keep in mind the surgery center also charges a no-show fee of their own as their staff is a separate entity.

Rescheduling Appointments: If you need to reschedule, we can accommodate 2-time changes and on the 3rd time a **\$10 USD fee** will be automatically added to your patient account balance and will be billed out accordingly.

Rescheduling Procedures: If you need to reschedule a surgical procedure and it is within **48 hours of your procedure**, there will be a **\$35 USD fee**, for **each time** the procedure is rescheduled.

Patient Printed Name

Patient Signature

Date

Bardmoor Gastroenterology & Wellness Insurance Policies Notification

It is the patient's responsibility to notify the office of any change in their insurance (changes must be communicated two weeks prior to a standing appointment). 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. Not all insurance companies will pay 100% of our charges. The patient (and/or spouse, guarantor) is responsible to pay all sums if 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. There are over 1000 insurance plans in America. 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 of insurance 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, *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 to your address, telephone number, or insurance information. Your insurance cards must 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

Bardmoor Gastroenterology & Wellness Office Policies

Co-Payments & Payments:

Copays are collected at the time of visit, according to current insurance information, unless otherwise arranged in advance. Payment is due upon receipt of the services provided by the doctor. Cash, credit cards, and checks are accepted.

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, if requested in advance.

Refills:

The patient is asked to please give our office 72 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. There will be a \$10 USD charge for refills done over the phone, instead of during a visit. This will be done only during regular business hours.

Test, Lab, and Procedures Results

In NO scenario will results of tests, labs or procedures be given to someone on the phone. Patients need to speak to the physician (unless a physician gives clearance to a medical assistant) for all results in accordance with HIPAA policy.

Medical Records:

1. Copying of medical records requires a medical record release signed by the patient before records are copied. It must be signed in person, if not otherwise arranged, with a copy of the ID.
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 and/or sent out.
3. No medical records will be faxed with the exception of faxing to another physician's office.

Patient Printed Name

Date

Patient Signature

Bardmoor Gastroenterology & Wellness Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information. We must safeguard your Protected Health Information and give you this Notice about our privacy practices that explains how, when, and why we may use or disclose your Protected Health Information. Except in the situations set out in the Notice, we must use or disclose only the minimum necessary Protected Health Information to carry out the use or disclosure. We may use and disclose your information as follows without your permission:

For treatment purposes. We may disclose your health information to doctors, nurses and others who provide your health care. Ex: your information may be shared with people performing lab work or x-rays.

To obtain payment. We may disclose your health information to collect payment for your health care. For instance, we may release information to your insurance company, or their collecting entities.

For health care operations. We may use or disclose your health information to perform business functions like employee evaluations and improving the service we provide. We may disclose your information to students training with us. We may use your information to contact you to remind you of your appointment or to call you by name in the waiting room when your doctor is ready to see you.

When required by law. We may disclose your Protected Health Information to law enforcement officers, courts, or government agencies. For example, we must report abuse, neglect, or certain physical injuries.

For public health activities. We may be required to report your health information to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety.

For health oversight activities. We may be required to disclose your health information to government agencies so that they can monitor or license health care providers such as doctors and nurses.

For activities related to death. We may be required to disclose your health information to coroners, medical examiners, and funeral directors so that they can carry out duties related to your death, such as determining the cause of death or preparing your body for burial. We also may disclose your information to those involved with locating, storing or transplanting donor organs or tissue.

For studies. To serve our patient community, we may use or disclose your health information for research studies, but only after that use is approved by UWM's Institutional Review Board or a special privacy board. In most cases, your information will be used for studies only with your permission.

To avert a threat to health or safety. To avoid a serious threat to health or safety, we may disclose health information to law enforcement officers or other persons who might prevent or lessen that threat.

For specific government functions. In certain situations, we may disclose health information of military officers and veterans, correctional facilities, government benefit programs, and national security reasons.

For workers' compensation purposes. We may disclose your health information to government authorities under workers' compensation laws.

For fundraising purposes. We may use certain information (such as demographic information, dates of services, department of service, treating physicians, and outcomes) to send fundraising communications.

The only other situation in which your patient information will be shared is if you sign a release of information and designate to whom it will be released, these records will be given at your discretion based on dates you select and specific types of information you choose to share. If you'd like the form to designate a release of your medical records, please ask the office and present a valid ID.

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Release of Information Due to Treatment, Payment and/or Healthcare Operations

I, _____, hereby authorize Bardmoor Gastroenterology (Dr. Bidani and/or Dr. Stenzel) 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 & Wellness 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 & Wellness restrict 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. I have read thoroughly the outlined pages provided to me and I attest that I am of sound mind and am willingly entering into this patient/provider agreement.

Printed Name of Patient

D.O.B.

Signature of Patient

Date

Printed Name of Patient or Patient’s Representative

Relationship to Patient

Bardmoor Gastroenterology & Wellness
 8787 Bryan Dairy Road, Suite 340, Largo, FL 33777
 Telephone (727) 393-1155 Fax (727) 320-9634

Authorization To Obtain Patient Information from Physician

I, _____ (print name) born on _____ (date of birth),
 hereby consent to the disclosure of the specific information listed below to:

Doctor: _____
 Telephone Number: _____
 Fax Number: _____
 Address: _____

The information I'd like to be released should include:

____ All medical records
 ____ Only operative reports
 ____ Specific dates of treatment: from _____ to _____.
 ____ Other: _____.

NOTICE: This is subject to revocation at any time in writing but may not be revoked to include release allowed by this document. I understand that this information is given by my free will, and I am of sound mind. I also understand that the practice does not have control of what the designated person chooses to do with this information once it leaves the practice.

 Printed Name or Legal Representative

 Patient Signature

 Relationship

 Date of Signature

Bardmoor Gastroenterology & Wellness
8787 Bryan Dairy Road Suite 340 Largo, FL 33777
HIPAA Confidentiality Information

Individuals' Right under HIPAA to Access their Health Information 45 CFR 164.524

"The privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice." Our office requires patients and their representatives to sign this Access Form directing release of PHI to other individuals.

Patient Name: _____ D.O.B.: _____

Patient Representative: _____

Notice: Requesting Medical Records (PHI) From Our Office (Please select one below):

Option 1: ALL records will be disclosed

Please list all family members or other person(s) if any, to whom we may disclose your protected health information, including treatment and payment information. These people will have full access to your protected health information and are able to request copies of your medical records (PHI) and may also have full online portal access to your records.

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Option 2: LIMITED records will be disclosed

Please list all family members or other person(s), if any, whom we may disclose your protected health information, including treatment and payment information. These persons will NOT have full access to your PHI. Sexual Health Information allowed to be withheld by state law must be withheld as well as Mental Health and Drug Use protected by Disclosure of Substance Use Disorder Patient Records: Title 42 of the Code of Federal Regulation (CFR). These people will have the ability to request medical records (PHI), but will not be given access to the patient portal as our office is unable to segment records in the portal.

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

- I hereby consent for the practice to disclose protected health information (PHI) about me to the person or persons listed above in the manner described. This release of PHI is in addition to the releases disclosed in our Notice of Privacy Practices.
- I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. This Access Request does not have an expiration date. Patients are required to notify our office of any changes they would like to make.

 Printed Name or Legal Representative

 Patient Signature

 Relationship

 Date

If other than the patient is signing, are you the legal guardian, custodian or have power of attorney for this patient for payment and/or treatment? Yes No