FLORIDA DIGESTIVE SPECIALISTS
Gastroenterology and Liver Disease Management
5651 49th St. N. St. Petersburg FL, 33709
Phone: 727-443-4299
1417 S Belcher Rd. Ste A Clearwater FL, 33764
Fax: 727-443-0255

DEAR VALUED PATIENT:

We know that as a patient you have many options for your Gastroenterology and Liver Disease Management Care, and we thank you for choosing our practice to help you with your continued care. We strive to provide high quality care in a professional and ethical manner

Please complete the enclosed forms. If you have questions or need assistance, please let us know. Bring these completed forms with you, along with your Photo ID, insurance card(s), and copay to your appointment. If you do not have your Photo ID, insurance card(s) and copay the day of your appointment, you will be rescheduled.

Patients arriving later than 15 minutes past their expected arrival time will be considered late and may be asked to reschedule.

It is the patient's responsibility to verify coverage for our facilities. Should your insurance change after you have scheduled your appointment, please contact our office at (727) 443-4299, Option 5.

We will contact you by phone with your lab/test results, if necessary, within a reasonable time frame. If you have not heard from us within 10-14 days, please contact our office

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FLORIDA DIGESTIVE SPECIALISTS, CONSENT FOR TREATMENT & COMMUNICATION, ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
AND
AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

CONSENT TO TREATMENT

I, the undersigned, acting on my behalf or as the legally authorized representative of _____ (PATIENT) hereby consent to examination, diagnostic testing and treatment by Florida Digestive Specialists (FDS) and its employees. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment provided by FDS.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of my medical information, including protected health information concerning my treatment to any third-party payor, including but not limited to health plans and insurers, Medicare, Medicaid, TRICARE and CHAMPVA for payment purposes.

Further, I authorize payment of any insurance or other benefits that may be made on my behalf by any party, including any health plan or insurer, Medicare, Medicaid and any other federal or state health care programs, directly to FDS. I understand that this assignment of benefits does not relieve me of my obligation to pay FDS for any charges not covered by this assignment or not paid by insurance or health care benefits.

I understand and agree, whether I sign as Agent or Patient, that I am responsible for and guarantee payment of any charges incurred for the services provided to PATIENT by FDS. I further understand and agree that I will be responsible for payment of any deductible, co-payment, coinsurance amounts, or any charge that is not covered or paid by insurance, health care benefits or third-party payors

I authorize FDS to release PATIENT's medical information, including HIV testing and treatment information, to other parties (which may include providers, payors, business associates or other entities) for the purpose of treatment, payment or healthcare operations.

Signature of Patient or Patient's Legal Representative ☐ *

_____ Date: _____

Name of Patient's Legal Representative and relation to Patient

** By checking the box and typing your name above, you are signing this agreement electronically. You agree that this electronic signature is the legal equivalent of your manual and/or handwritten signature, and by checking the box you acknowledge, agree, and are legally bound to this agreement's terms and conditions.*

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COMMUNICATIONS CONSENT

_____ (initial) I authorize Florida Digestive Specialists (FDS) to leave telephone messages for PATIENT that may contain medical information at the following number(s):
_____

_____ (initial) I authorize FDS to contact PATIENT at the following email address:
_____

_____ (initial) I authorize FDS to share PATIENT medical information with:

Name/Relationship: _____ Name/Relationship: _____

Name/Relationship: _____ Name/Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you are agreeing that you have received a copy of FDS's Notice of Privacy Practices, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Signature of Patient or Patient's Legal Representative ☐ * Date: _____

_____ Date: _____
Name of Patient's Legal Representative and relation to Patient

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Last Name _____ First Name _____ Date of Birth: _____

REASON FOR VISIT: Please describe the problem which prompted your visit _____

Date of last Colonoscopy? _____ Where was it performed? _____

Date of last Endoscopy? _____ Where was it performed? _____

Do you have a family history/relatives with colon cancer? Yes or No Relation: _____

Do you have family history/relatives with colon polyps? Yes or No Relation: _____

Please list any lab tests, procedures or X-ray/radiology studies performed (e.g. by another physician or ER visit), that may relate to your current problem and where you had them done:

ALLERGIES TO MEDICATIONS: Please list all prescribed OR over the counter medications/supplements (including vitamins and herbal compounds) please include the dose and frequency for each medication.

_____

MEDICATIONS: Please list all prescribed OR over-the-counter medications you are currently taking. Please include the dose and frequency for each medication listed. (If more room needed, please write on back of this form)

Name of Medication	Dose	How Often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SURGICAL HISTORY: Please list ANY operations/surgical procedures performed in the past 5 years?

_____

HOSPITALIZATIONS: Please list any medical illnesses that required hospitalization (other than for surgery or childbirth)

_____

Do you currently use tobacco products? Yes or No Have you ever used tobacco products? Yes or NO

Do you currently use recreational/illicit drugs? Yes or No If so what type _____

Have you previously used recreational/illicit drugs? Yes or No If so what type_____

Alcohol: Yes or No How many drinks per day _____ Per Week _____ Per Month_____

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Anesthesia Pre-op Questionaire

Patient Name:_____
Gender:_____ Age:_____

Please Fill Out This Form Completely!
Do you currently have or have had a history of any of the following?

Cardiovascular

☐Y ☐N Shortness of breath walking 2-3 blocks
# of blocks you can walk_____
# of stairs you can climb_____
☐Y ☐N Pacemaker/Defibrillator
Type: _____

Date last integrated:_____

☐Y ☐N Heart Attack less than 6 months ago
☐Y ☐N Have A-fib or other abnormal rhythm
☐Y ☐N Heart Tranplant
☐Y ☐N Heart Surgery or stents
☐Less than 6 months ago
☐Y ☐N Chest Pain
☐Y ☐N Congestive Heart Failure/ CHF
☐Y ☐N Ventricular Assist Device/ VAD
☐Y ☐N Heart Disease/ Coronary Artery Disease
☐Y ☐N High Blood pressure

Pulmonary

☐Y ☐N Pulmonary Hypertension
☐Y ☐N Lung Transplant
☐Y ☐N Part of lung removed/ resected
☐Y ☐N Do you use oxygen at home?
☐Daytime ☐Nighttime
☐Y ☐N Sleep Apnea
☐Severe ☐Moderate ☐Mild
☐Y ☐N Do you use a CPAP/ BiPAP?
☐Y ☐N COPD/Emphysema/Asthma
How often do you use a rescue inhaler?_____

Hematologic/ Neurologic

☐Y ☐N Stroke/ Mini Stroke / TIA
☐Less than 6 months ago
☐Have weakness
☐Y ☐N Seizures
☐Daily ☐Weekly ☐Monthly
☐Y ☐N Bleeding/ Clotting disorder
☐Y ☐N Blood clot less than 12 months ago?
☐Y ☐N Taking blood thinners? (other than Aspirin)

Renal/Endocrine/Gastrointesitnal

☐Y ☐N Kidney problems/ Failure
☐Dialysis?
What Days?_____
☐Y ☐N Kidney Transplant?
What year?_____
☐Y ☐N GERD/ Acid reflux
☐Y ☐N Liver Disease/ Hepatitis
☐Y ☐N Diabetes
☐on insulin?

Anesthesia Problems

☐Y ☐N Post-op nausea or vomiting
☐Y ☐N Prolonged sedation/ intubation
☐Y ☐N Awareness under anesthesia
☐Y ☐N Have you been told you were difficult to place a breathing tube?
☐Y ☐N Malignant Hyperthermia
☐ You ☐Family Member

Miscellaneous

☐Y ☐N Fever > 100 F in the past month
☐Y ☐N Respiratory infection/ Pneumonia In the past month?
☐Y ☐N Use of Drugs?
☐Marijuana **☐Crack/Cocaine**
☐methamphetamines ☐IV Drugs
☐Y ☐N History of smoking/ current smoker
☐Y ☐N Alcohol use of 2 or more drinks per day

Patient Signature ☐

Date:_____

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