Advanced Gastroenterology of South Florida, PA

Karthik Mohan, DO
Board Certified Internal Medicine
Board Certified Gastroenterology
Gastroenterology
Palmetto Medical Plaza
7100 West 20 Ave, Suite 301
Hialeah, Florida 33016

Phone (305) 556-3727 Fax (305) 556-3711

PATIENT INFORMATION

Last Name _____ First Name _____ DOB ___/___/___

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

SS# ____-____-____ e mail address _____

Marital Status □ Single □ Married □ Separated □ Divorced □ Widowed

Name of Employer _____ Occupation _____Employer Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Care Physician _____ Phone _____

Pharmacy Name _____ Phone _____

Reason for the visit

_____

_____

_____

INSURANCE INFORMATION

Insurance Name _____ Member ID _____

Group Number _____ Effective date ____/____/____

Subscriber's Name _____ DOB ___/___/___ Relationship _____

Do you have an Advance Directive? □ Yes □ No If yes, please provide a copy of it to Advanced Gastroenterology of South Florida, PA at your earliest possible convenience.

An Advance Medical Directive is the direction you give about the kind of health care you wish to have if you lose ability to make decisions. Consult a lawyer in connection with your right to execute such Advance Medical Directive.

CONSENT

I authorize Dr. Karthik Mohan to leave NORMAL test results on my answering service □ YES □ NO

If I am not available to receive my test results, I authorize **Advanced Gastroenterology of South Florida, PA** to release this information to

_____

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PATIENT INFORMATION

Date _____

Name _____ Date of Birth _____ Social Security _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

e-mail address _____

Occupation _____ Employer _____

Person to notify in case of emergency _____ Relationship _____ Phone _____

Insured Information _____ Relationship _____ Phone _____
If different than above

Insurance Company (1) _____ Insurance Company (2) _____

Plan 1 ID Number _____ Plan 2 ID Number _____

Plan 1 Group Number _____ Plan 2 Group Number _____

SOCIAL HISTORY

Do you live: Alone □ With Spouse □ with Family □ Other _____

Religion _____ Marital Status: Married □ Single □ Widowed □ Divorced □

Please Indicate **TOBACCO USE** Yes □ No □

Please indicate **ALCOHOL USE**

How may glasses/cans do you drink _____ daily _____ weekly _____ occasionally

PAST MEDICAL HISTORY: Do you now or have YOU ever had any of the following.

CANCER

□ Colon Cancer
□ Esophageal Cancer
□ Stomach Cancer
□ Breast Cancer
□ Pancreatic Cancer
□ Endometrial Cancer
□ Barrett's Esophagus
□ Liver Cancer
□ Leukemia
□ Lymphoma

LIVER

□ Hemochromatosis
□ Cirrhosis
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Jaundice
□ Fatty Liver

NEUROLOGICAL

□ Stroke
□ Seizures
□ Migraines
□ Other Headache

RESPIRATORY

□ COPD (Emphysema)
□ Asthma
□ Tuberculosis (TB)
□ Sleep Apnea
□ Collapsed Lung

RENAL

□ Kidney Stones
□ Kidney Failure
□ Dialysis

HEART

□ High Blood Pressure (Hypertension)
□ Heart Attack (Myocardial Infarction)
□ Angina
□ Congestive Heart Failure
□ Premature Heart Disease in Family
□ Palpitations
□ Mitral Valve Prolapse
□ Elevated Triglycerides
□ Elevated Cholesterol (Hyperlipidemia)
□ Rheumatic Fever
□ Heart Valve Disease
□ Endocarditis

ENDCRINOLOGY

□ Diabetes, Type I (Insulin needed)
□ Diabetes Type II (pills needed)
□ Thyroid Disease
□ Hypothyroid
□ Hyperthyroid

MUSCULOSKELETAL

□ Fibromyalgia
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Raynaud's
□ Lupus
□ Sjogrens
□ Scleroderma
□ Gout

GASTROINSTESTINAL

□ IBS-Irritable Bowel Syndrome
□ Diverticulitis
□ Diverticulosis
□ Peptic Ulcer Disease
□ Gallstones
□ GERD
□ IBD –Crohn's
□ IBD –Ulcerative Colitis
□ Pancreatitis
□ GI bleeding
□ Constipation
□ Chronic Liver Disease
□ Colon Polyps

PHYSCHOLOGICAL

□ Bipolar
□ Anxiety
□ Depression
□ Obsessive Compulsive Disorder
□ Schizophrenia

BLOOD

□ VonWillebrands'
□ Hemophilia
□ Bleeding or clotting abnormalities

Hepatitis Risk Factors	
□ IV Drug Abuse □ Borne between 1945 - 1965 □ Received clotting factors made before July 1992 □ History of chronic hemodialysis □ Prior work in the military □ Born to a Hepatitis infected mother □ Healthcare, emergency and public safety workers with needle stick exposure	□ History of abnormal liver tests □ HIV infection □ Tatoo/Body piercing □ Sexually transmitted diseases or multiple sex partners

MEDICATIONS. Please indicate PRESCRIBED and OVER THE COUNTER medications including vitamins, supplements, medicated drops and injections

MEDICATION	DOSE	START DATE	PRESCRIBED BY

SURGICAL PROCEDURES / HOSPITALIZATIONS. Indicate date of any surgeries you have had/

GASTROINTESTINAL _____

GYNECOLOGICAL _____

CARDIAC _____

Hx OF COLONOSCOPY? _____ DATE _____

Hx OF UPPER ENDOSCOPY? _____ DATE _____

OTHER _____

WHAT MEDICAL PROBLEM BROUGHT YOU TO SEE THE DOCTOR TODAY?

_____

_____

_____

WHAT DATE DID THE SYMPTOMS START? _____

WHAT MAKES THE SYMPTOMS BETTER? _____

WHAT MAKES THE SYMPTOMS WORSE? _____

PREVIOUS TREATMENT

Emergency Room YES ☐ NO ☐ WHERE? _____

Doctor's Office YES ☐ NO ☐ WHERE? _____

ALLERGIES

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Tetanus Other _____

CHECK ALL DISEASES THAT HAVE OCCURRED IN YOUR FAMILY AND INDICATE FAMILY MEMBER AFFECTED

☐	Cirrhosis of Liver	☐	Colon Polyps	☐	Colorectal Cancer	☐	Chronic Pancreatitis
☐	Acute Pancreatitis	☐	Liver Disease	☐	Gastric Cancer	☐	Ulcerative Colitis
☐	Crohn's Disease	☐	Diabetes, Insulin Dependant	☐	Irritable Bowel Syndrome	☐	Gallstones
☐	Peptic Ulcer Disease	☐	Heart Disease	☐	Breast Cancer	☐	Gynecological Cancer

☐ Other _____

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MEDICAL RELEASE FORM

I authorize release my medical records to Advanced Gastroenterology of South Florida, PA.

Patient's Name _____ DOB _____

Social Security _____

PURPOSE OF DISCLOSURE

□ Personal Use □ Legal Purpose □ Insurance Purpose

□ Other _____

INFORMATION TO BE RELEASED

□ Consult
□ Discharge Summary
□ Lab Report
□ Radiology Reports
□ Pathology Reports
□ ALL
□ Other _____

This authorization shall be valid for 90 days from the date of signature or the date of completion of treatment whichever is later, unless otherwise expressly revoked by me in writing prior to that time.

If records are mailed to a physician of another medical facility, I will incur in a prepaid charge of $1.00 per page as copying fee.

Patient's Signature _____ Date _____

Legal Guardian Signature _____ Date _____

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NEW PATIENT CONSENT TO USE DISCLOSURE OF HEALTH INFORMATION TREATMENT, PAYMENT OR HEALTHCARE OPERATION

I _____, understand that as part of my healthcare, Advanced Gastroenterology of South Florida, PA originates and maintains paper and electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A toll for routine healthcare operations such as assessing quality and renewing the competence of healthcare professionals.

I understand and I have been provided with a *Notice of Information Practices* that provides a more detailed description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent.
- The right to object to use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be disclosed to carry out treatment, payment or health care operations.

I understand that Advanced Gastroenterology of South Florida, PA's care is not required to agree to the restrictions requested. I also understand that I may revoke this consent in writing, except to the extent that the organization has already taken action. Further, I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of Code Federal Regulations.

Advanced Gastroenterology of South Florida, PA reserves the right to change their notice and practices in accordance with Section 164.520 of the Code if Federal Regulation.

I understand that as part of Advanced Gastroenterology of South Florida, PA's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and, I consent to such disclosures for these permitted uses, including disclosure via fax.

I fully understand and □ accept or □ decline the term of this.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

__ Consent Reviewed by _____ Date _____

__ Consent refused by patient and treatment refused as permitted.

__ Consent added to the patient's medical record on _____

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CARE OF A MINOR AUTHORIZATION

Patient's Name _____Date of Birth____/____/___

Parent or Guardian Name _____

I hereby authorize Advanced Gastroenterology of South Florida, PA to provide any necessary medical care and treatment to my minor child mentioned above.

This authorization expires on the minor's eighteen (18^{th}) birthday.

Parent or guardian signature _____

Date _____

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POLICY ON INSURANCE AND ASSIGNMENT OF BENEFITS

Name _____

As physicians, our relationship is with you, not your insurance company. Please understand that:

- **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract**.
- Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "usual, customary, and reasonable fees" for this region. This statement does not apply to companies who reimburse based on arbitrary "schedule" of fees which bears no relationship to the current standard and cost of care.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover, and do not readily disclose this fact until after the service has been rendered.
- Only one procedure is done per visit. If necessary, a follow-up visit may be scheduled to discuss results.

For HMO patients: Your insurance carrier allows up to 5 visits without a referral and thereafter requires you to have a referral to visit Dr. Mohan. If you do not have a referral, your visit will be deferred, delaying your treatment and care.

I hereby instruct and direct my Insurance Company, to pay by electronic deposit of funds or check made payable to Advanced Gastroenterology of South Florida, PA.

If my current policy prohibits direct payment to a doctor, I hereby also instruct and direct you to make out the check to me and mail it to the address above, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this assignment shall be considered as effective and valid as the original
- I authorize Advanced Gastroenterology of South Florida, PA to deposit checks received on my account
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Signature of Patient/Policy Holder Date

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FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need to ensure your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa and American Express. **To ensure a stress-free visit, please verify that Dr. Karthik Mohan participates with your insurance plan**. It is not possible to keep up with all plans available today.

Claims for insurance companies with which Dr. Mohan participates, are submitted electronically. For those insurance companies with whom we do not participate, we are pleased to provide you with an itemized bill, that you can submit for reimbursement.

All co-pays and coinsurance amounts are due at the time of service and, cannot be waived. All patient balances, as determined by your insurance company, are due and payable within 30 days of our invoice. All balances over 30 days are automatically forwarded to our billing company. All balances over 60 days are **automatically** referred to a **collections agency** and assessed a **$100.00 collection fee**. Please pay your balance promptly. If you have financial difficulties, please notify us as soon as possible to avoid this eventuality.

Returned, unpaid checks will be added to your account with a **$35.00 charge**.

_____ _____
Signature of Patient/Policy Holder Date

_____ _____
Signature of Policy Holder if other than patient Witness

I have read Advanced Gastroenterology of South Florida, PA notice of Privacy Rights.

Signature _____

Date _____

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NOTICE OF PRIVACY PRACTICE –SHORT FORM

Our Practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPAA) along with a brief overview of our Notice of Privacy. Our practice is complying with HIPPAA's regulations.

What is HIPPAA and how does the Privacy Rule affect you?

The Health Insurance Portability Act (HIPPAA) of August of 1996 gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient and we are required by law to be complaint with this regulation. Under the Privacy Rule, you are guarantee access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following our practice's policy. We are dedicated to maintain the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?

IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Practice posted in our waiting room and you can ask for a copy of the current notice at any time. This notice applies to all records created or retained by our practice. We can update our Notice of Practices at any time.

The following categories describe the different ways in which we may use and disclose your IIHH.

∗ Treatment ∗Appointment Reminders ∗ Payment ∗ Treatment Options ∗ Release Information to Family/Friends∗ Health Care Operations ∗ Disclosure Required by Law ∗ Health Related Benefits and Services

The following categories describe unique situations in which we may use or disclose your IIHI.

∗ Public Health Risks ∗ Health Oversight Activities ∗ Lawsuits and similar proceedings ∗ Deceased Patients ∗ Military ∗ Organ and Tissue Donation ∗ Research ∗ Law Enforcement ∗ National Security Inmates ∗ Workers Compensation ∗ Serious Threats to Health or Safety

What are your rights concerning your IIHI?

1. Confidential Communication
2. Amendment
3. Right to a Paper Copy of this Notice
4. Requesting Restrictions
5. Accounting of Disclosures
6. Inspections and Copies
7. Right to file a Complaint
8. Right to provide an Authorization for Other Uses and Disclosures.

Please contact our office if you have any questions regarding this notice.

I have read the short form notice provided by **Advanced Gastroenterology of South Florida, PA** and have been informed of how to obtain more information regarding the Notice of Privacy.

Patient Name _____ **Signature** _____ **Date** _____