DIGESTIVE DISEASES ASSOCIATES OF TAMPA BAY, LLC
PATIENT INFORMATION SHEET

PLEASE PRINT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address where you reside: _____

City, State, and Zip Code: _____

Billing Address (if different from above: _____

Date of Birth: ___/___/___ Sex: Male ____Female: ____ Social Security Number: ____/____/_____
We ask for your Social Security Number because we need it to interact with Hospital, Insurance Companies, and government agencies. We will protect this information with the same care that we protect your other confidential medical records.

Primary Contact Telephone Number: _____ Home, Work, Cell, Other (circle one)
This is the main number that we will use to contact you for all communications. It should be a number with an answering machine or voice mail connected to it.
Alternate Contact Telephone Number: _____ Home, Work, Cell, Other (circle one)
Other Alternate Contact Telephone Number: _____ Home, Work Cell, Other (circle one)

E-Mail Address: _____

We ask for your race, ethnicity, and preferred language in accordance with the Health Information Technology for Clinical Health (HITECH) Act as required to meet United States Department of Health and Human Services regulations for Meaningful Use Certification. Though we are required to ask for this information you may choose to decline.

Your preferred language (circle one): English, Spanish, Other: _____. I decline to answer.
Marital Status (circle one): Married, Single, Separated, Divorced, Widowed
Ethnicity (circle one): Non-Hispanic, Hispanic, Latino, Patient refused
Race: _____

Preferred Method of Communication (Please Indicate):
Mail: _____ Phone: _____ E-Mail: _____ My Chart: _____

Primary Care Physician: _____
Address: _____
Phone Number: _____

Referring Doctor: _____
Address: _____
Phone Number: _____

Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

Patient Employer: _____
Address: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Information:
Name of Insurance Company: _____

Insured's Name: _____ SS#: _____ Date of Birth: _____

Insurance Member Number: _____ Group Number: _____

Does this insurance require a referral from a primary care physician? Yes _____ No _____
If yes, was the referral obtained: Yes _____ No _____ Copay Amount: _____

Secondary Insurance Information:
Name of Insurance Company: _____

Insured's Name: _____ SS#: _____ Date of Birth: _____

Insurance Member Number: _____ Group Number: _____

Does this insurance require a referral from a primary care physician? Yes _____ No _____
If yes, was the referral obtained: Yes _____ No _____ Copay Amount: _____

IMPORTANT INFORMATION:

PLEASE READ CAREFULLY: All charges or co-payments, if applicable, are due at the time of services. All professional services rendered are charged to the patient. The patient is responsible for all fee regardless of insurance coverage unless the services are covered under a contractual agreement between the Medical Practice and your insurance carrier. Patient will be responsible for any COST incurred in the Collection or Litigation of any unpaid balance.

AUTHORIZATION OF RELEASE INFORMATION: I hereby authorize Digestive Diseases Associates or its physicians to release any information acquired in the course of my examination or treatment to: (insurance company or attorney). A copy of this authorization shall be considered as valid as an original.

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and required payment of medical insurance benefits to the party who accepts assignment. I understand that I am responsible for any amount not covered by my insurance company.

Patient Signature: _____ Date: _____

DIGESTIVE DISEASES ASSOCIATES OF TAMPA BAY, LLC
876 S PARSONS AVE.
BRANDON, FL 33511

PATIENT MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

DATE: _____ REFERRING DOCTOR: _____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

HIGH BLOOD PRESSURE _____
CONGESTIVE HEART FAILURE _____
SEIZURES _____
BLOOD IN STOOLS _____
HEART ATTACK _____
THYROID DISEASE _____
KIDNEY DISEASE _____
TUBERCULOSIS _____
PULMONARY EMBOLUS _____
DIABETES _____
COLITIS _____
CROHNS _____
ANEMIA _____
STROKE _____
HIGH CHOLESTEROL _____
PANCREATITIS _____
ASTHMA _____
COLON POLYPS _____
CANCER (TYPE) _____ _____
HEPATITIS (TYPE) _____ _____
LIVER DISORDER _____
BLOOD CLOTS (IN BLOOD VESSELS) _____
SICKLE CELL _____
OTHER: _____

REASON FOR TODAY'S VISIT: _____

HAVE YOU EVER HAD A COLONOSCOPY OR EGD (UPPER ENDOSCOPY): YES _____ NO _____ IF YES, WHICH PROCEDURE AND INDICATE DATE: _____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO: _____

LIST ANY SURGERIES YOU HAVE HAD AND THE DATE: _____

ANY PROBLEMS WITH SURGERY OR ANESTHESIA: YES _____ NO _____

DO YOU SMOKE: YES _____ NO _____ HOW MUCH AND HOW LONG? _____
DO YOU DRINK: YES _____ NO _____ HOW MUCH? _____

<u>HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE LIST WHO</u>.

CROHNS _____	**HEPATITIS _____**	**ANEMIA _____**
CANCER COLON _____	**DIABETES _____**	**HIGH BLOOD PRESSURE _____**
CELIAC DISEASE _____	**STROKE _____**	**COLITIS _____**
COLON POLYPS _____	**LIVER DISORDERS _____**	**KIDNEY DISORDERS _____**

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MEDICATION LOG

PATIENT NAME: _____

DATE OF BIRTH: _____

PHARMACY NAME: _____
PHARMACY PHONE NUMBER: _____
PHARMACY LOCATION: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

ALLERGIES: YES ____ NO _____ IF YES, PLEASE INDICATE: _____
_____.

NAME OF MEDICATION	DOSAGE AND FREQUENCY

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It is our policy NOT TO RELEASE confidential and/or unauthorized information by telephone, answering machine, work telephone or cell phone. Whenever returning phone call and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. <u>If you would like to have information released to someone other than you or have messages left, please complete the following:</u>

I authorize Digestive Diseases Associates and its staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

HOME TELEPHONE: YES _____ NO _____ PHONE NUMBER: _____

ANSWERING MACHINE: YES _____ NO _____ PHONE NUMBER: _____

CELL PHONE/VOICE MAIL: YES _____ NO _____ PHONE NUMBER: _____

WORK TELEPHONE: YES _____ NO _____ PHONE NUMBER: _____

Please note: Other than your health insurance policy and your referring doctor, we will require a signed consent to release medical information.

<u>Please list names of people we can discuss your medical care with:</u>

SPOUSE: _____ YES _____ NO_____

PARENT: _____ YES _____ NO _____

OTHER RELATIONSHIP: _____ YES _____ NO _____

PATIENT SIGNATURE: _____

DATE: _____

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FINANCIAL POLICY

The doctors and staff at Digestive Diseases Associates would like to welcome you to our practice. We strive to provide you with excellent medical care.

BY SIGNING BELOW, YOU CONFIRM THAT YOU HAVE READ AND UNDERSTAND OUR OFFICE POLICY.

It is your responsibility to inform our office of any address and telephone number changes. Your account is to be kept current accordingly; all self-pay or insurance co-pays and deductibles will be collected at the time of service. We take checks, MC, Visa, American Express and Discover. A return check will result in a $25.00 service charge and all future payments must then be made with a credit card.

You will be sent a statement each month if your balance exceeds $2.00.

Refunds will be issued at the end of each month if there are not insurance claims pending. There is a $40.00 charge for completion of requested paperwork (FLMLA, DISABILITY, AND ECT). Please allow 30 business days for completion of requested paperwork.

If your account is turned over to a collection agency, you will be responsible for any cost incurred in collection of said balance and must work with the collection agency to pay the balance, not our office.

We submit your claims, however we must emphasize that as a medical provider, our relationship is with you not your insurance company.

It is your responsibility to inform us of any changes in your insurance coverage. If your insurance company requires a referral from your primary care physician, it is your responsibility to have the referral faxed to our office prior to your appointment. Our office will allow you to bring your referral at your appointment time. However, if our office does not have the referral at your appointment time, you may be asked to reschedule your appointment until the referral is obtained.

It is your responsibility for non-covered charges not payable by your insurance company. Although filing your insurance claim is a courtesy extended to you, all charges are always your responsibility.

We realize that temporary financial problems may affect payment of your account. If such problems do arise, we urge you to contact our billing department at 813-685-1210 for assistance in management of your account. If you have any questions, please do not hesitate to ask us.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

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PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgement of Receipt of Digestive Diseases Associates' Privacy Practices.

Patient's Name: _____
S.S.N.: _____ Date of Birth: _____

Understand that the patient's health information is private and confidential. I understand that Digestive Diseases Associates personnel work very hard to protect the patient's privacy and preserve the confidentiality of the patient's person health information.

I understand that Digestive Diseases Associates may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission, by a subpoena via court order. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Digestive Diseases Associates has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is on display in the waiting room and also available from the office staff. I understand that I have the right to read the "Notice" before signing this acknowledgement.

Digestive Diseases Associates may update this acknowledgement and "Notice of Privacy Practices". If I ask, Digestive Diseases Associates will provide me with a most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These procedures may include other signature requirements, written acknowledgement, and authorizations; reasonable time frame for requesting information; charges for copies and non -routine information needs; etc. I will assist Digestive Diseases Associates by following the procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Digestive Diseases Associates "Notice of Privacy Practices".

Patient Signature: _____ Date: _____ Time: _____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.…

Would you like to discuss your PHI with any other individual (e.g. spouse, child)? ___yes___no

mychart.tgh.org

Digestive Diseases Associates of Tampa Bay, LLC is happy to announce that as of May 1,2015 our goal is to have all patients registered with mychart.tgh.org. This portal will allow all patients to have direct access to their own medical records. It also provides patients with direct access to the clinical staff and will allow patients to receive a response to their questions or concerns in a timely manner.

<u>As of May 1, 2015 all medication refills need to be requested electronically through mychart or from the pharmacy through the electronic refill system.</u>

You will be provided with a user name and a temporary password. You will need to provide us with your email and the answer to a security question.

E-mail Address: _____

What state were you born: _____

Once you get home, we advise that you log into your account and reset your password.

User Name: _____

Password: _____

Thank you for your cooperation in this matter. This will allow our staff to better assist each patient in a timely manner.

Digestive Diseases Associates of Tampa Bay, LLC
876 S Parsons Avenue
Brandon, FL 33511
813-653-3359