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: _____

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LIST ANY SURGERIES YOU HAVE HAD AND THE DATE: _____

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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: _____DOB: _____

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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**DIGESTIVE DISEASES ASSOCIATES OF TAMPA BAY, LLC**
**PATIENT INFORMATION SHEET**

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

Residential Address: _____

City, State, and Zip Code:_____

Mailing Address (if different from above): _____

Date of Birth: ___/___/___ Sex: Male ____Female: ____ Social Security Number: ____/____/_____

Marital Status (circle one): Married Single Separated Divorced Widowed

Preferred language: English Spanish Other:_____

Ethnicity (circle one): Non-Hispanic Hispanic/Latino Patient refused

Race: White Black Asian Pacific Islander American Indian/Alaskan Native Hawaiian More than one race

Primary Telephone Number: _____ Home, Work, Cell, Other (circle one)

Alternate Telephone Number: _____ Home, Work, Cell, Other (circle one)

E-Mail Address: _____

Primary Care Physician: _____ Referring Doctor:_____

Address:_____ Address:_____

Phone Number:_____ Phone Number:_____

Emergency Contact Name:_____ Phone: _____Relationship to Patient:_____

Patient Employer: _____
Address: _____ Phone: _____

INSURANCE INFORMATION

Name of Primary Insurance: _____Plan Type:_____

Subscriber's Name: _____SS#: _____Date of Birth: _____

Member Number/Subscriber ID: _____ Group Number: _____

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

Name of secondary Insurance: _____

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

Member Number/Subscriber ID : _____ Group Number: _____

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**Patient Name:_____ DOB:_____**

**Authorization to 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.

**Permission for Treatment** I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to DDA to administer and perform all examinations, treatments, diagnostic procedures and surgeries needed now or in the future. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. Photocopy of this consent is to be considered as valid as the original

Patient Signature: _____ Date: _____

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# HIPAA NOTICE

## Patient Consent for use and disclosure of Protected Health Information

DDA will not release information to anyone unless we have written authorization to do so. I am responsible to notify DDA whenever this information changes. I authorize DDA to disclose protected health information to the following:

**LIST NAMES OF THOSE WE CAN SHARE YOUR HEALTH INFORMATION WITH**

| **Name** | **Relationship** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Acknowledgement of Privacy Practices

DDA 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, posted on our website and available from the office staff. I understand that I have the right to read the "Notice" before signing this acknowledgement.

I hereby acknowledge that I have been given a chance to review DDA's Notice of Privacy Practices as required by law

Patient Signature: _____ Date: _____

## Permission to Leave a Message

Ok to leave medical information pertaining to your care on voicemail/answering machine? YES NO

Preferred # to call:_____

Please note: Other than your health insurance and your referring doctor, a signed consent to release medical information is required.

PATIENT NAME (PLEASE PRINT): _____DOB:_____

PATIENT SIGNATURE: _____

DATE: _____

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## Financial Policy

This is an agreement between DDA, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money orders, cashier's check, Visa, MasterCard, Discover, and American Express.

**Insurance:** Insurance is a contract between you and your insurance company. We will file insurance claims **only** for plans with whom we have a contract. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front and back of the insurance card, photo ID, and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All co pay, coinsurance and deductibles are due at the time services are rendered.

If your insurance requires a referral and/or preauthorization, you are responsible for obtaining the referral. Failure to obtain the referral and/or preauthorization may result in your appointment being rescheduled. We will assist you in obtaining referrals/authorizations required.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

**Collection Fee:** A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

**Waiver of Confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**Returned Checks:** There is a fee currently of **$25.00** for any checks returned by the bank. Payment made on a returned check must be made in cash, money order, or credit card.

**Copying of records:** You will need to request in writing and pay a reasonable copying fee for copies of your records. You authorize us to include all relevant information, including payment history. If you are requesting records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**Completion of Forms:** There is a $40.00 pre-pay for completion of requested paperwork. Please allow 30 business days for completion.

**Effective date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

**My signature below certifies that I have read (or the form as been read to me) and I understand the contents on this form.**

Print Patient Name:_____ DOB: _____

Patient Signature (or Legal Guardian):_____Date:_____

If Legal Guardian, Relationship to Patient: _____