

Georgia
Colon & Rectal
Surgical Associates, P.C.

Dr. _____

Account #: _____

Patient Information Form

Patient Name: _____
(First) (M.I.) (LAST) (Suffix: Jr., M.D.)

Apt., Bldg., Unit, Etc.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell / Work/ Other _____

Email Address: _____

Sex M F Marital Status M S D W

Date of Birth (MM/DD/YY) ____/____/____ Social Security Number _____

Emergency Contact Name _____

Emergency Contact Relationship _____

Emergency Contact Phone Number _____

Referring Doctor _____ Phone _____

Primary Care Physician _____ PCP Phone _____

Primary Insurance Effective Date: (MM/DD/YY) ____/____/____

Company Name: _____

Group #: _____ Policy #: _____

Please provide the following information on the policy subscriber below:

Subscriber Name _____ Sex M F
(Policyholder's Name)

Social Security Number _____ Date of Birth (MM/DD/YY) ____/____/____

Subscriber's Employer _____

Employer Address _____ Suite _____

City _____ State _____ Zip _____

Work Phone Number _____ Ext. _____

I hereby authorize the release of any medical information, including HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for healthcare related utilization review or quality assurance activities. I authorize any physician, hospital, or clinic to provide details of my medical history to Georgia Colon & Rectal Surgical Associates, P.C. I hereby assign and authorize payment to Georgia Colon & Rectal Surgical Associates, P.C. of all medical and/or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insurance program or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Georgia Colon & Rectal Surgical Associates, P.C. by any insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Signature: _____

Date: _____

Georgia Colon & Rectal

SURGICAL ASSOCIATES, P.C.

Name: _____

Today's Date: _____ Age: _____ Gender: Male / Female (circle)

Chief complaint _____
(why are you here?)

Your Symptoms

(check all that apply)

- Diarrhea Constipation Incontinence (loss of bowel control)
 Abdominal pain Bloating Nausea/vomiting
 Rectal bleeding Swelling around the anus Prolapse (tissue coming out of the anus)
 Anal pain Itching Burning

Past medical history (check all that apply)

- Heart disease High blood pressure Stroke Heart attack _____ (year)
 High cholesterol Angina or chest pain Heart murmur Heart surgery
 Implanted defibrillator or pacemaker
 Lung disease Asthma Tobacco use _____ (packs per day)
 Diabetes Type I _____ Type II _____ Low thyroid
 Cancer If so, what kind? _____
 Crohn's disease or ulcerative colitis _____
 Irritable bowel syndrome _____ Colon polyps _____

Medications: _____

Daily aspirin? Y/N On Plavix? Y/N On Coumadin? Y/N

Allergies to medications _____

Past Surgical History (please give dates)

Colonoscopy _____ Physician _____ Date _____

Colon surgery _____ Physician _____

Anal or rectal surgery _____ Physician _____

Artificial joints _____

Heart valves _____ On Coumadin? Y/N

Hysterectomy _____

Obstetric: _____ # pregnancies _____ # vaginal deliveries _____ # C-sections

History of episiotomy or tear _____

Other: _____

Family History:

Relationship to you:

Age at diagnosis:

Breast cancer _____

Ovarian cancer _____

Uterine cancer _____

Thyroid cancer _____

Colon / Rectal cancer _____

Ulcerative colitis _____

Crohn's disease _____

Polyps _____

FAP _____

Other: _____

Medical conditions: Diabetes / High cholesterol / Heart disease / Lung disease

Georgia Colon & Rectal Surgical Associates

770-277-4277
www.gcrsa.com

Authorization for Voicemail Delivery of Medical Information

In an effort to provide efficient, quality, patient-friendly medical care by avoiding the "phone tag" issues often associated with informing patients of their test results, we have developed this Authorization for Voicemail Delivery of Medical Information.

HIPAA (Health Insurance Portability & Accountability Act of 1996) provides specific guidelines to protect patient's privacy specifically restricting Protected Health Information (PHI). Detailed information regarding HIPAA, PHI and patient privacy can be found in the Notice of Privacy Practices which you received on your first visit to our office following the enactment of HIPAA. Additional copies of the Notice of Privacy Practices are available from the receptionist.

I authorize Georgia Colon & Rectal Surgical Associates, and its physicians and employees to leave detailed messages specific to my medical care including test results on the phone number(s) listed below. I understand that once a voicemail message exists it is no longer covered under HIPAA and therefore is not protected from unauthorized access. This authorization is effective _____.

I understand that this authorization can be revoked at anytime by submitting a written request to the practice. Unless revoked sooner, this authorization to release detailed medical information will expire one (1) year from the effective date listed above.

Home Voicemail: Yes No Phone Number: _____

Work Voicemail: Yes No Phone Number: _____

Cellular Voicemail: Yes No Phone Number: _____

Speak with spouse/partner: Yes No Phone Number: _____ Name: _____

Other family member: Yes No Phone Number: _____ Name: _____

Preferred Pharmacy Information

Pharmacy Name: _____

Address: _____

Telephone: Fax: _____

e-Prescribing allows your physician to send eligible new prescriptions and refills to your pharmacy electronically. It is a highly convenient process that maximizes prescription accuracy and eliminates the need for patients to keep up with paper prescriptions. It significantly lessens the wait time associated with dropping off prescriptions to your pharmacy after your visit or having a staff member to call it in. Prescriptions arrive to your pharmacist instantaneously.

I would like a copy of this notice for my records: Yes No

Patient Name: _____ Birth Date: _____

Signature: _____ Date: _____

Georgia Colon & Rectal Surgical Associates

Financial and Insurance Policy

Every individual's insurance policy is different, so please take the time to become familiar with your insurance plan. Your insurance company may or may not cover certain procedures. To help avoid uncovered services, it is important that you understand your plan's coverage by referring to your insurance handbook or contacting your insurance provider prior to your appointment.

Here are a few questions you may want to ask your insurance provider:

- 1) *Is a referral needed from my Primary Care Physician (PCP) in order to see a specialist?*
- 2) *Does my policy require an office appointment co-payment? (co-payment is the dollar amount required to be paid by the patient at the time of service).*

Policy:

- If your health care plan requires a referral from your primary care physician (PCP) and one is not provided to GCRSA prior to your visit, fees for your office visit will be your responsibility and paid at the time of service. Obtaining a referral is the patient's responsibility.
- Payment is due for any open balance within 30 days from receipt of your billing statement.
- Past due balances must be paid in full prior to any additional visits unless advanced arrangements have been made with our Business Office.
- Patients without insurance will be considered as "self pay" and required to pay all office visit fees at the time of service, and a 50% deposit of our allowable charge will be required before a surgical procedure will be scheduled, with the balance due paid within 30 days.
- We appreciate your kind consideration by providing us with 24 hour notice when canceling or rescheduling your office visit.
- Due to the increased administrative costs for reserving a hospital operating room, and coordinating our surgeon's schedule, we will reserve the right to access up to a \$200 fee for your scheduled surgery not canceled or rescheduled within 3 business days.
- GCRSA requires a 10 business day return window for administrative services. Administrative services and fees includes, but is not limited to: *filling out forms for FMLA, short / long term disability (\$30) and making copies of medical records (\$25).* **Payment is required prior to being picked up, faxed or mailed.**

I have read and agree to the terms of Georgia Colon & Rectal Surgical Associates Financial and Insurance Policy.

Patient / Guardian responsible for payment signature: _____

Date: _____