710 Oak Commons Boulevard • Kissimmee, Florida 34741
3100 17th Street, Suite 3104 • St. Cloud, Florida 34769
339 Cypress Parkway, Suite 230 • Kissimmee, Florida 34759

Phone (407)846-6747 • Fax (407) 846-6186

NAME ______________________________ AGE____ MALE____ FEMALE ____
LAST FIRST MIDDLE

ADDRESS ______________________________

CITY ______________________ STATE________ ZIP CODE ____________

HOME PHONE# ______________ CELLULAR#______________ WORK # ______________

DATE OF BIRTH______________ SOCIAL SECURITY # ______________________

MARITAL STATUS: __ MARRIED __ DIVORCED __ SINGLE __ SEPARATED __ OTHER

EMPLOYERS:______________________________

SPOUSE: ______________________________

EMERGENCY CONTACT ______________________ PHONE# ______________

E-MAIL ADDRESS: ______________________

DO YOU HAVE INSURANCE COVERAGE: __YES __NO (*See Financial Policy.*)

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND PHOTO ID TO BE SCANNED.

IF YOU ARE NOT THE INSURED PERSON, PLEASE COMPLETE THE FOLLOWING:

INSURED'S NAME: ______________________________ DOB:______________

INSURED'S EMPLOYER: ______________________________

INSURED'S S.S#: ______________________ RELATIONSHIP TO YOU:______________

Who is your primary care DOCTOR or Referring PHYSICIAN?______________________

How did you hear about us?______________________________

MEDICARE PATIENTS - if you have Medicare and it is not your primary insurance, we have to know the reason that your Medicare is secondary.
Please answer the following questions:

I am entitled to Medicare coverage because of:

Age____ Disability____ End stage renal disease____

Check all that apply for Medicare secondary coverage:

____ I am employed full time and have employer health insurance
____ My spouse is employed and I am covered under employer plan
____ Receiving Black Lung benefits
____ Services are paid by a government research program
____ Department of Veterans Affairs is responsible
____ Due to a work related illness/injury ____ non-work related

I hereby assign all medical or surgical benefits to which I am entitled to, including Medicare/Private Insurance/Major Medical Benefits and any other health plan to M. Siraj ul Islam, M.D., Syed K. Lateef, M.D., Jaime M. Rivera, M.D., Celia Ann Quinnonez, M.D., Mahmudul Haq, M.D., and Carla Fuentes-Blanco, ARNP (Gastroenterology Associates of Osceola, P.A.).

I also give my permission to Gastroenterology Associates of Osceola, P.A. to release any and all medical records to the respective doctors and insurance companies upon request, without notifying me in advance.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as the original. I understand that I am financially responsible for all charges not paid 100% by the insurance companies, unless other arrangements are made with the physician or office manager.

Upon the visit to the office, I am required to present the receptionist with my medical insurance information. This office will bill primary and secondary insurance only (secondary will be billed one time). Co-payments, co-insurance and deductible amounts are due and payable upon arrival at office for appointment.

This office DOES accept Medicare assignment. If you do not understand what Medicare assignment is, please feel free to ask the receptionist, he/she will be glad to explain this to you.

The Hospital/Kissimmee Endoscopy Center and the doctor are two separate businesses. The office does not bill for Hospital/Kissimmee Endoscopy Center charges and the Hospital/Kissimmee Endoscopy Center does not bill for the doctor's charges. Medicare has a separate deductible with the Hospital/Kissimmee Endoscopy Center, there is still a chance that your deductible for the physician has not yet been met. If you have any questions in regard to your deductible, please contact your insurance company to find out if there is a deductible for both Hospital/Kissimmee Endoscopy Center and doctor. Medicare has a "Part A" and a "Part B" deductible. This office will bill your secondary for deductible, however, if not paid, will become the patient's responsibility.

I have read the above information and I understand fully all information.

Patient Signature	**Date**
Patient Name (Please Print)	**Witness**

THE DOCTORS DO NOT PRESCRIBE PAIN KILLERS. THEY WILL NOT REFILL ANY PRESCRIPTION WRITTEN BY ANOTHER PHYSICIAN.

710 Oak Commons Boulevard • Kissimmee, Florida 34741
3100 17th Street, Suite 3104 • St. Cloud, Florida 34769
339 Cypress Parkway, Suite 230 • Kissimmee, Florida 34759

Phone (407)846-6747 • Fax (407) 846-6186

Dear Patient:

It is most likely that you are going to have an endoscopic procedure (that is looking in your esophagus, stomach, duodenum or colon). There are special procedures like ERCP, PEG tube placement and so on. These procedures require pain medicine (namely Fentanyl or Nubain), and sedatives (Versed or Valium). Endoscopics are very common procedures and thousands of them are done on a daily basis all over the country. Our physicians are all well trained in endoscopy. Almost always the procedures go smoothly, but like anything in life there is some chance of complication.

Upper endoscopy may cause throat irritation, bloating, aspiration. If during a colonoscopy polyps are removed, then immediate or late bleeding may require repeat procedure, blood transfusion, or even surgery. Rarely, there might be perforation that will require immediate surgery. Infection may develop after a procedure as well. Injection of the above medications may cause burning pain, allergic reaction, swelling of injection site or blockage of vein in the long run. If an ERCP is performed, the dye injection may cause acute pancreatitis which may require short term or long term hospitalization, and occasionally, may require surgery. All procedures are done under a monitoring system. In spite of all the precautions, there might be life threatening complications, like respiratory arrest or cardiac arrest. Since no procedure is perfect, a missed lesion is a possibility as well.

Even though most of these complications are rare, we would like to make you aware of them. If you have any questions, please ask us during your office examination or prior to the procedure. You will be signing a consent form at the facility where the test will be performed.

I have read the above and give permission to do the procedure, if necessary.

____________________ ____________________
Date Signature of the Patient

____
Signature of Legal Guardian

710 Oak Commons Boulevard • Kissimmee, Florida 34741
3100 17th Street, Suite 3104 • St. Cloud, Florida 34769
339 Cypress Parkway, Suite 230 • Kissimmee, Florida 34759

Phone (407)846-6747 • Fax (407) 846-6186

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION

Consent to Treatment The patient and/or authorized representative does hereby consent to any and all medical treatments which may deem advisable by the physician(s) of Gastroenterology Associates of Osceola, P.A.

Authorization for Release of Confidential Information: I hereby authorize Gastroenterology Associates of Osceola, P.A. to release medical information contained in my/the patient's records to any insurance carrier, employer or other third party intermediary utilized by the patient for the purpose of obtaining information and/or reviewing the record of medical care received by the patient and for the payment of all medical charges, Copies of records may also be sent to referring physicians for continuity of care. Medical records released nay include any diagnostic or therapeutic information of visits and/or procedures performed in the office. Unless initialed below the records may not include any confidential information regarding:

____ Alcohol
____ Substance Abuse
____ Mental Health
____ HIV

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) The patient's medical records may not be furnished to and the medical condition of the patient may not be discussed with any person other than the patient, the patient's legal representative, or other health care practitioners involved in the care and treatment of the patient without the patient's written authorization. The patient may at this time authorize an individual to be actively involved in the patient's information as mentioned above:

____

Name Relation

Assignment of Insurance Benefits: I assign payment directly to Gastroenterology Associates of Osceola, P.A. of the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment. I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.

Medicare Patients: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Gastroenterology Associates of Osceola, PA, to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or related Medicare claim, I hereby authorize payment directly to Gastroenterology Associates of Osceola, P.A. medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to, routine testing may not be covered by Medicare unless the physician provides medical necessity.

Pre-authorization: Your insurance company may require pre-authorization for office visits and/or procedures. I understand that if proper authorization is not obtained from my PCP (primary care physician) I will be liable for charges incurred.

Patient/Guarantor Agreement: I understand that Gastroenterology Associates of Osceola, PA. is not in the business of extending credit. Therefore, it is the policy of Gastroenterology Associates of Osceola, P.A. to require payment in full at the time of service. If unable to pay payment due balance in full at the time of service, I agree to make prior arrangements with the Billing Department.

I understand that I am financially responsible for my/the patient's account with Gastroenterology Associates of Osceola, P.A. regardless of my insurance benefits.

I authorize a copy of this form to be valid as the original.

Advanced Directives: ❑ I have Advanced Directives. ❑ I do not have Advanced Directives.

Patient/Responsible Party: ______________________________

Date: ____________________ Witness: ______________________________

710 Oak Commons Boulevard • Kissimmee, Florida 34741
3100 17th Street, Suite 3104 • St. Cloud, Florida 34769
339 Cypress Parkway, Suite 230 • Kissimmee, Florida 34759

Phone (407)846-6747 • Fax (407) 846-6186

Authorization for Release of Information

I, hereby authorize_________________________

____

(Please include Doctor's full name, address, telephone, and fax numer if applicable.)

to disclose the following protected health information to:

Gastroenterology Associates of Osceola, P.A.

Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provide, level of detail to be released, origin of information, etc.

This protected health information being used or disclosed to carry out treatment, payment and/or health care operations of Gastroenterology Associates of Osceola, P.A., for the purpose of continuity of care.

This authorization shall be in force and effect until ____
Date or event that relates to the purpose of the disclosure

at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Office Manager of Gastroenterology Associates of Osceola, P.A. I understand that a revocation is not effective to the extent that Gastroenterology Associates of Osceola, P.A. has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Gastroenterology Associates of Osceola, P.A. will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

______________________________	______________________________
Signature of Patient or Personal Representative	Signature of Witness
______________________________	______________________________
Date	Date
______________________________	______________________________
Name of Patient or Personal Representative	
______________________________	
Description of Personal Representative's Authority	

CS1-5 (GP33),12/11/14

710 Oak Commons Boulevard • Kissimmee, Florida 34741
3100 17th Street, Suite 3104 • St. Cloud, Florida 34769
339 Cypress Parkway, Suite 230 • Kissimmee, Florida 34759

Phone (407)846-6747 • Fax (407) 846-6186

NOTICE OF PRIVACY PRACTICES

IMPORTANT: THIS NOTICE DESCRIBES YOUR RIGHTS AS A PATIENT AND HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED.

PLEASE REVIEW THIS NOTICE CAREFULLY AND ACKNOWLEDGE RECEIPT BY SIGNING AT THE END OF THE NOTICE.

The terms of this Notice of Privacy Practices apply to Gastroenterology Associates of Osceola, P.A. and are effective April 14, 2003. This organization and its employees will share individual patient health information as is necessary to provide quality health care and receive reimbursement for those services as permitted by law. This office is required by law to maintain the privacy of our patients individual health information and to provide patients with notice of privacy practices with respect to your individual health information. We reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be available in this office, or, upon request to Office Manager, Gastroenterology Associates of Osceola, P.A., 710 Oak Commons Blvd., Kissimmee, FL 34741, a copy may he mailed to your address maintained on file.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Except as described below, this office will maintain the confidentiality of your individual health information. Your individual health information may be used and disclosed as customary and reasonable for purposes of treatment, payment, and health care operations and pursuant to a signed authorization form permitting the use or disclosure. You have the right to revoke that authorization in writing unless any action has been taken in reliance on the authorization.

Treatment, Payment, and Health Care Operations. Except as otherwise provided, or with your signed consent, this office will use and disclose your individual health information as necessary for purposes of your treatment, payment, and as necessary and permitted by law, for our health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc.

Family and Friends. With your approval and using our best judgment, individual health information may be disclosed to designated family, friends, and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited individual health information with such individuals without your approval.

Business Associates. At times it may be necessary for us to provide your individual health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your information.

Appointments and Services. This office may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your individual health information from us by alternative means or at alternative locations. You may request such confidential communication in writing and may send your request to Office Manager, Gastroenterology Associates of Osceola, P.A., 710 Oak Commons Blvd., Kissimmee, FL 34741. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make the request by sending your name and address to Office Manager, Gastroenterology Associates of Osceola, P.A., 710 Oak Commons Blvd., Kissimmee, FL 34741 with your request to be removed from our marketing mailing lists.

Other uses and disclosures of your individual health information, permitted or required by law, may be made without your consent or authorization.

- The release of your individual health information for any purpose required by law;
- The release of your individual health information for public health activities, such as required reporting of disease, injury and

birth and death, and for required public health investigations;

- The release of your individual health information as required by law if we suspect child abuse or neglect; we may also release your individual health information as required by law if we believe you to be a victim of abuse, neglect. or domestic violence;
- The release of your individual health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- The release of your individual health information to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;
- The release of your individual health information if required by law to a government oversight agency conducting audits. investigations, or civil or criminal proceedings;
- The release of your individual health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- The release of your individual health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- The release of your individual health information to coroners and/or funeral directors consistent with law;
- The release of your individual health information if necessary to arrange an organ or tissue donation from you or a transplant for you;
- The release of your individual health information if you are a member of the military as required by armed forces services; we may also release your individual health information if necessary for national security or intelligence activities; and
- The release of your individual health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

YOUR RIGHTS

1. Access to Individual Health Information. You have the right to copy and/or inspect much of the individual health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you a fee per page if you request a copy of the information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You may obtain an access request form from Office Manager, Gastroenterology Associates of Osceola, P.A., 710 Oak Commons Blvd., Kissimmee. FL 34741.

2. Amendments to Individual Health Information. You have the right to request in writing that individual health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from Office Manager, Gastroenterology Associates of Osceola, P.A., 710 Oak Commons Blvd., Kissimmee, FL34741.

3. Accounting for Disclosures of Individual Health Information. You have the right to receive an accounting of certain disclosures made by us of your individual health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from Office Manager. Gastroenterology Associates of Osceola, P.A., 710 Oak Commons Blvd., Kissimmee, FL 34741. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period.

4. Restrictions on Use and Disclosure of Individual Health Information. You have the right to request restrictions on certain of our uses and disclosures of your individual health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by as, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to Office Manager, Gastroenterology Associates of Osceola, P.A., 710 Oak Commons Blvd., Kissimmee. FL 34741.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with Office Manager, Gastroenterology Associates of Osceola, P.A., 710 Oak Commons Blvd., Kissimmee, FL 34741. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

ADDITIONAL INFORMATION

If you have questions or need additional assistance regarding this Notice, you may contact the Office Manager at (407) 846-6747.

SIGNATURE: ______________________________ Date ______________

PATIENT OR AUTHORIZED REPRESENTATIVE

SCREENING COLONOSCOPY QUESTIONNAIRE

Patient Name: ______________________________ DOB: ________________

__ Yes __ No Have you ever had a colonoscopy? If yes, when: ________________

Where: ____

__ Yes __ No Have you ever had colon polyps? If yes, date of last colonoscopy: ____________

When: ____________ Where: __________________________

__ Yes __ No Have you ever had intestinal surgery?

__ Yes __ No Have you had any previous problems with sedation?

__ Yes __ No Current Medical Problems: ________________________________

____

__ Yes __ No List of current medications: ________________________________

____

____

__ Yes __ No Drug allergies? If so, what medication: __________________________

__ Yes __ No Latex allergy?

__ Yes __ No Do you have cardiomyopathy?

__ Yes __ No Do you have a defibrillator?

__ Yes __ No Do you take any blood thinners?

__ Yes __ No Do you have emphysema?

__ Yes __ No Do you have sleep apnea?

__ Yes __ No Do you have kidney disease or kidney failure?

__ Yes __ No If so, are you are on dialysis?

______________________ ______________________________

Date Patient Signature