THE COLON AND RECTAL CLINIC
FT. LAUDERDALE | Committed to Excellence in Surgical Care of the Colon and Rectum.

The Bennett Building
201 NW 82nd Ave Suite 307 Plantation Florida 33324
Medical Arts in the Springs
2901 Coral Hills Drive Suite 360 Coral Spring Florida 33065

*Phone: (954) 236-5444 * Fax: (954) 236-5422*
www.crcftlauderdale.com

Charles P. Lago, Sr., M.D, F.A.C.S., F.A.S.C.R.S **Joseph P. Corallo, Jr. MD** **Maria Rojas, MD**

PLEASE COMPLETE THIS FORM ENTIRELY AND TO THE BEST OF YOUR ABILITIES

Name: _____ Date: _____

Primary Care Physician/Gastro/Specialist: _____

Which symptom/reason brought you here today? _____

Please list ALL Allergies: _____

Please list ALL Medications: _____

Please list ALL Previous Surgeries: _____

Please list ALL Pertinent Family History: (i.e. COLON CANCER/POLYPS, BREAST CANCER, ETC.) _____

_____

Colonoscopy: Yes___ Month/Year: _____ No: ____
Do you smoke? Yes___ No___ /Have you ever smoked? Yes___ No___

WEIGHT: _____ HEIGHT: _____

PAST/CURRENT MEDICAL CONDITIONS(S): PLEASE CHECK ALL THAT APPLY

Arthritis: _____Gallbladder: _____ Kidney disease: _____ Psychiatric: _____
Bleeding: _____ Gastritis: _____ Liver Disease: _____ Skin Conditions: _____
Cancer: _____ Heart disease: _____ Lung disease: _____ Thyroid: _____
Colitis: _____ High Blood Pressure: ____ Ophthalmologic: _____ Issues with Anesthesia: _____
Diabetes: _____ HIV: _____ Peptic Ulcer:_____ Issues with local anesthesia: ____
Diverticulitis: ____ Hormonal/Uterine: _____Prostate: _____

Please fill out the following to the best of your abilities. These are now requirements by Medicare

If you wish to opt out or decline please check this box ☐

SCREENING FOR DEPRESSION

Are you currently experiencing depression? YES__ or NO__

1. Little interest or pleasure doing things?

Not at all__ Several Days__ More Than Half the Days__ Nearly Everyday__

2. Feeling down depressed or hopeless?

Not at all__ Several Days__ More Than Half the Days__ Nearly Everyday__

3. Feeling tired or having little energy?

Not at all__ Several Days__ More Than Half the Days__ Nearly Everyday__

4. Trouble falling or staying asleep?

Not at all__ Several Days__ More Than Half the Days__ Nearly Everyday__

5. Trouble concentrating on such things as reading or watching TV?

Not at all__ Several Days__ More Than Half the Days__ Nearly Everyday__

6. Moving or speaking so slow that other people could have noticed?

Not at all__ Several Days__ More Than Half the Days__ Nearly Everyday__

7. Moving or speaking so fast or being fidgety or restless?

Not at all__ Several Days__ More Than Half the Days__ Nearly Everyday__

8. Thoughts you would be better off dead or hurting yourself in some way?

Not at all__ Several Days__ More Than Half the Days__ Nearly Everyday__

FALL SCREENING

PLEASE CIRCLE

Are you 65 or older? YES or NO --- If no, please skip to the next page

1. History of falling (immediate or previous): **YES or NO**

2. Have you fallen more than 2 times in the past year: **YES or NO**

3. Ambulatory Aid: **NONE BEDREST NURSE ASSIST**

4. Walking/Balance: **NORMAL BEDREST/WHEELCHAIR WEAK**

5. Mental Status: **NORMAL IMPAIRED**

If you answered anything other than not at all for depression screen or are considered at risk for falling, Please contact your primary doctor today. We can provide a copy of this report to you. Thank you for your cooperation

PATIENT INFORMATION FORM

PLEASE PRINT

PRIMARY CARE DOCTOR: _____
PRIMARY CARE PHONE #: _____ PRIMARY CARE FAX #:_____
PATIENT NAME:_____SEX: MALE OR FEMALE
SOCIAL SECURITY #: _____ BIRTHDATE: _____
MARITAL STATUS: S M W D AGE:____ PHONE #: _____
STREET ADDRESS: _____APT #:_____
CITY: _____ STATE:_____ ZIPCODE: _____
EMAIL: _____
EMPLOYER/SCHOOL: _____ TITLE: _____ PHONE #: _____
STREET ADDRESS: _____ CITY: _____ STATE:___ ZIP:_____
SPOUSE: _____ AGE:_____ BIRTHDATE: _____
SPOUSE EMPLOYER: _____ TITLE: _____ PHONE #:_____
STREET ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY

NAME: _____ PHONE #: _____RELATIONSHIP: _____
STREET ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY_____ ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE #: _____
ID #: _____GROUP NAME OR #: _____
INSURED'S FULL NAME: _____ INSURED'S DOB: _____
RELATIONSHIP TO INSURED: SELF___ HUSBAND___ WIFE___ OTHER____

GUARANTEE OF PAYMENT

I duly understand that I am directly responsible for payment to the physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to collect payments. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of the examination or treatment to my insurance company for the purpose of processing any insurance claims.

ASSIGNMENT OF INSURANCE BENEFITS

If the insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the physicians in this office for medical or surgical treatment received by me in this circumstance. Furthermore, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature: _____ Date: _____

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MEDICAL RELEASE FORM

To: _____

Phone #: _____ Fax #: _____

I, _____, authorize you to furnish
(PLEASE PRINT)
a copy of my medical records to the Colon and Rectal Clinic of Ft. Lauderdale.
I release you from all legal responsibility or liability that arises from this authorization.

Comments:
_____

****** **Patient Signature**: _____
Date of birth: _____ **Date**: _____

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Patient Acknowledgement

if anyone calls or comes in on your behalf, we cannot talk to and/or release any medical information unless their name is present on this form.

I acknowledge that I have been provided with The Colon and Rectal Clinic of Fort Lauderdale/SFSS PRIVACY NOTIFICATION and I have read fully and understand this notice.

Patient Name (PRINT): _____

Patient Signature: _____

***Spouse/Family/Friend Name:** _____

Email: _____ Date: _____

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REFERRAL POLICY

The purpose of this note is to inform you of our office policy regarding referrals.

Unfortunately, the referral process can be tremendously difficult for all parties involved. We understand your frustration. You, as the patient, will need to contact your primary care physician for all referrals. The referrals will need:

- To be valid and non-expired
- To list any special codes needed such as:

  - New Patient Codes: **99204**
  - Follow-up Codes: **99213, 99214** and **99215**
  - Procedure Codes**: 46600, 45330, 46221** and **46060.**

For your convenience, we will accept faxed referrals. The referrals will need to be in the office prior to your appointment. Prior to arriving for your appointment, please feel free to contact us to verify the referrals have been received. This will make your visit efficient and as comfortable as possible. Requesting a copy of your referral, if one has not been provided to you, will enable you to track when and if a referral is needed.
If you do not have a valid referral upon arriving to your appointment, you have the option of rescheduling or paying upfront fees for the for the office visit with hope of reimbursement from your insurance carrier. Please keep in mind if you are paying out of pocket for the initial visit, you will have to pay out of pocket for surgery fees if surgery is needed as well as facility anesthesia and pathology fees. It is in our experience that without a referral, you will rarely get reimbursed. Again, thank you so much for bearing through this process with us.

I, _____, have read and understand the above policy.

_____

Signature Date

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Co-payments and payments for FMLA/Disability, etc. are due at the time of service unless special arrangements have been made. The billing department will gladly file insurance claims on my behalf; however, payment cannot be guaranteed. I understand that the billing department will make every effort and several attempts to obtain payments and/or clarify my insurance carrier's decisions regarding my outstanding balance. In the event that the insurance company misquoted my benefits, my benefits changed, or any other reason that the insurance company denies my claims, I will also be responsible for any unpaid balances not covered by my insurance company. I will also be responsible for a $45.00 charge for any checks returned for insufficient funds.

Patient Signature: _____ Date: _____

I am also acknowledging my understanding that since my appointment time has been set aside exclusively for me, that I am responsible for notifying my practitioner 24 hours in advanced to avoid a $25.00 cancellation fee. I am aware that my insurance company will not pay for missed appointments.

Patient Signature: _____ Date: _____

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Surgery Cancellation/Rescheduling Policy

In order for us to maintain our efficiency in the operating room, as well as giving full consideration to the hospital and anesthesia staff, it is necessary for us to implement a cancellation/rescheduling policy. It is important that when you schedule your surgery/procedure you have thoroughly checked your personal calendar to make sure that your scheduled date is ideal for you. Canceling or rescheduling your surgery/procedure requires multiple phone calls to the hospital or outpatient facility, insurance company, patient and multiple resources.

We understand that sometimes it may be necessary to reschedule s surgical procedure due to personal illness, unforeseen circumstances.

However, the practice policy is:

Rescheduling/Cancellation less than two (2) weeks before procedure will result in a $100 fee

Rescheduling/Cancellation less than one (1) week before procedure will result in a $200 fee

Rescheduling/Canceling less than seventy-two hours before procedure will result in a $500 FEE

Rescheduling/Cancellation without notice, no-showing for the procedure will result in a fee equivalent to the cost of your surgery,

This reschedule/cancellation fee or no-show fee will be applied toward your procedure and will be added as a charge to your account that is NOT billable to insurance.

If the surgery is canceled by either Colon and Rectal Clinic of Ft. Lauderdale or the facility in which the procedure is scheduled there will be no fee charged to the patient

Thank you for your understanding.

_____

Patient Signature and Date

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

South Florida Surgical Services of Ft. Lauderdale
350 N Pine Island Rd.300
Plantation, FL 33324
954-236-5444

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt outof those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Signature: _____ **Date:** _____